Oregon Title V Maternal and Child Health

Five-Year Needs Assessment 2011

Office of Family Health, Oregon Health Authority
Oregon Center for Children and Youth with Special Health Needs,
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Oregon Title V – Maternal and Child Health
Five-Year Needs Assessment

1. Process for Conducting Needs Assessment

Goals and Vision

The Oregon Title V Programs began the Needs Assessment with the vision to enhance partnerships and engage new partners to create shared, meaningful goals for Oregon's maternal and child health populations and programs. The primary goal of Oregon's assessment was to assess priority issues as described by community and topical experts, as well as those who work with women, children, and families every day. The Title V Programs are committed to addressing those issues considered most urgent and challenging to the overall health status of both rural and urban communities around the state.

Leadership

The Oregon Title V Program is housed in two different agencies in Oregon. The Title V Director and fiscal agent for the Block Grant is located in the Office of Family Health (OFH), the Public Health Division, in the Oregon Health Authority. The Title V CSHCN Director is located at the Oregon Health and Science University, in the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), Child Development and Rehabilitation Center. Both agencies work closely to administer Oregon's Title V Program and MCH Block Grant, in partnership with community and local health department MCH programs and activities. Reference to the Oregon Title V Offices includes all programs and activities in both the Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs.

The Leadership Team for the MCH Needs Assessment included executive, management and research staff in both Title V Offices. Executive leadership included the Title V Director and OFH Administrator, Katherine J. Bradley and the Title V CYSHN Director and OCCYSHN Director, Marilyn Hartzell. Management and research staff from the Title V Offices provided oversight and project management for all the assessment processes in Appendix A. The Leadership Team met at least monthly to facilitate, guide, and make decisions about the progress and outcomes of the assessment. The Leadership Team was active in all aspects of the assessment, from development of the surveys, selection of Advisory Group members, and selecting priorities appropriate for action by the Title V Offices.

Methods

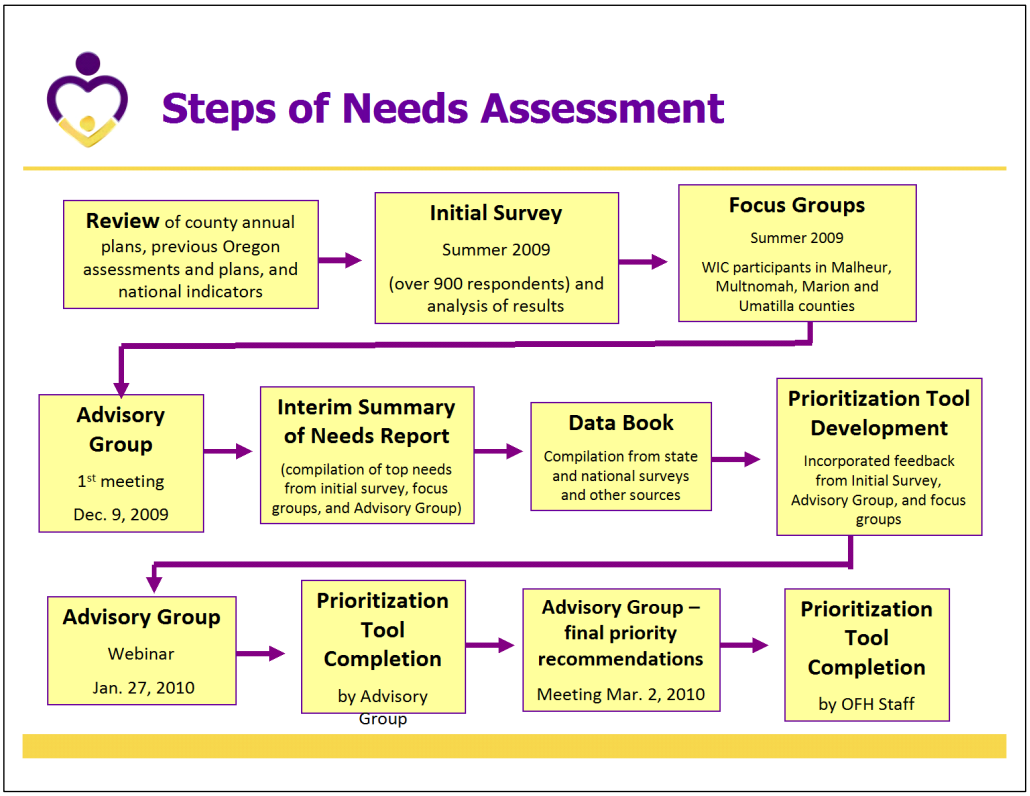
The methods for Oregon's Assessment covered a broad range in order to assure input from as many stakeholders and experts as possible and analysis that balances the quantitative and qualitative research. The methods covered three different processes: research, surveys, and engagement. Figure 1 is an illustration of the process for data collection and priority setting.

Research for the assessment began in summer 2009, and included collecting and analyzing many reports and assessments that had been completed in the couple years prior to that date. From that information, an on-line survey was created using the top issues for each population raised in those reports. An e-mail list was devised of over one thousand people working in local public health agencies, child care, schools, early intervention services, reproductive health services,

private medical care, mental health services, and services for children with special health needs. About 900 people responded to that survey.

Next, focus groups with WIC participants were conducted, asking mostly mothers of young children about their most challenging issues and priorities. While more focus group discussions were desirable as part of the assessment, capacity and time delayed this research and the Leadership made a decision to include more focus group on the priorities resulting from the assessment, particularly with those groups experiencing priorities. Focus groups will be conducted to collect information about the extent of disparities in health status and services, particularly around the selected priority areas.

Figure 1



The result of these early research and survey activities resulted in a "long list" of priorities. Data and indicators about each of these issues by population groups were compiled using multiple data sources. This created a "data book" to be used in conjunction with the next phase of the assessment, a community-based Advisory Group.

The Title V Advisory Group was convened in December, 2009, and the intent was to use the group as topical experts to help narrow the long list of priorities to recommendations for a short list that would result in the five-year goals for the Title V Program. The Advisory Group was recruited from leaders and organizations with an interest or work related to the health of women, children and children with special health needs. Effort was made to assure participants were representative or had expertise about Oregon's diverse populations and the disparities

experienced across MCH populations. The plan was for the group to meet three times to discuss the issues, create and administer a priority ranking tool based on their discussion and the first on-line survey, complement the tool with data about those issues in the Data Book, and then finalize priority recommendations in a final meeting. The Prioritization Tool and the Data Book are posted on the Advisory Group website at http://www.oregon.gov/DHS/ph/ch/mch_advisory.shtml.

Concurrent to the Title V Advisory Group was the "Child Health Collaborative," which is a partnership of the Association of Public Health Nurse Supervisors (AOPHNS) and the state Office of Family Health. This was a process to focus specifically on public health issues and priorities for a collaborative plan for state and local public health. This Collaborative was a follow up of a Perinatal Collaboration in 2008, which also identified priorities.

Title V policy and program staff helped facilitate the discussions at both community engagement activities, in order to hear first-hand the concerns and needs of the population, so that they also may provide expertise and recommendations to the Title V Leadership. One of the final steps to the assessment was to administer the same priority ranking tool for the Advisory Group to the Title V policy and program staff, and hold an internal discussion session to collect their input on the priorities.

Also concurrently as the Title V Advisory Group progressed, the Title V CYSHN program conducted a Family Survey and a Provider Survey to assess the needs of children and youth with special health needs and their families as well as those of community-based providers who serve this target population. The surveys were administered on-line using Survey Monkey and paper versions when requested. Spanish versions of the Family Survey were available in Survey Monkey and paper. Participants were recruited using multiple marketing strategies including email and direct mail to stakeholder groups, distributing information at conferences and meetings, and posting information on the web. Results were monitored and targeted outreach efforts were made to counties and stakeholder groups where participation was lacking. Analyses of the surveys were integrated into the needs assessment process. Results were shared with staff and key stakeholders to consider as the priorities were identified and refined for development. Plans are as yet underway to develop and administer a Youth Survey in FY 2011 to complete the Title V CSHCN process. Needs assessment is an ongoing process and the Title V CYSHN program will continuously monitor the emerging the needs of its target population.

The final priority issues presented to the Title V Leadership group for final decisions included the input of all of these processes. Surprisingly, the same issues, concerns and barriers were consistent through all of these priority-setting processes, with some variation about which population group was most affected by the issue area. The general priority areas are:

- Mental health
- Family violence
- Alcohol and drug abuse
- Oral health
- Overweight and obesity
- Parent skills and resources

- Access to specialized services
- Access to family supports

The priorities identified by the Child Health Collaborative and the Title V CYSHN Family and Provider surveys were largely consistent with those raised in the Title V Advisory Group, validating that these were important for focusing the state's Title V resources.

The Title V CYSHN Family and Provider Survey results identified greatest needs of families and their children to include respite care, care coordination, speech and occupational therapy, specialty care, mental health services and child care. Providers identified financial resources, respite care, and care coordination as the greatest needs of CYSHN.

Additional work to strategically plan and implement activities to address each of these areas will be forthcoming during implementation of the assessment recommendations.

MCH Population Assessment Methodology
Oregon assessed populations in categories that related best to the potential interventions and services. These groupings are:

- Women before and between pregnancies
- Pregnant women
- Mothers and infants
- Children ages 1 to 9
- Older children and adolescents ages 10-24
- Children and youth with special health needs (CYSHN), ages birth to 21

The assessment outcomes are organized by these population groups and the planning for interventions and analysis will be based on a life-course perspective.

State Capacity Assessment Methodology
Assessment of capacity in Title V Programs was collected through a few different methods. Primarily, the Title V Advisory Group process included significant discussions about opportunities, barriers, and infrastructure needs. Their commentary was captured and organized by Title V Pyramid Level and will be the primary source document used in planning for the activities. These documents can be viewed on the Title V Advisory Group website at: http://www.oregon.gov/DHS/ph/ch/mch_advisory.shtml. The Child Health Collaborative included strengths, weakness, opportunities and needs discussions to guide planning for priorities raised in that process that are relevant to the Title V priorities. The OCCYSHN needs assessment surveys of families and providers assessed greatest needs of families and their children, and the providers identified their training support needs and their perception of families' greatest needs. The Office of Family Health Staff prioritization survey and meeting provided initial assessment of the activities and capacity needs to address the priority issues.

Formal capacity assessment for the priority issues will be forthcoming in the early stages of planning activities for the priority areas. Methodologies for capacity assessment may vary

depending on the issue, the stakeholders and partners, and the level of existing work in the Title V Programs.

Assessment Data Sources

Initial Survey

The initial survey was an online survey that was designed to reach, as survey respondents, a broad audience of health care and social services providers and community leaders. This audience of potential participants included state and local public health providers, state and local providers of other governmental social services, school-based health centers, child care providers, and representatives of organizations such as health professional organizations, non-profit organizations, tribal organizations, community development/activist organizations, faith organizations, business and volunteer organizations.

Contact information for potential respondents was gathered from lists of current partners as well as other lists of community organizations. A link to the online survey was e-mailed to approximately 1,200 potential respondents. These respondents were asked to complete the survey themselves and also to forward the survey link to other potential respondents. Slightly more than 900 respondents participated.

In the survey, for each MCH population, a broad list of potential unmet needs was provided. For each potential unmet need, respondents were asked to rate the need as a top priority, medium priority, or lower priority for their community.

Strengths of this survey include the fact that the number of participants was quite large and the fact that we were successful both in reaching participants throughout the state and in including many participants outside of public health. One limitation of the survey was a lack of success in reaching substantial numbers of racial and ethnic minorities. Another limitation was that, due to the sampling method, it is impossible to evaluate how representative the sample was.

Focus Groups

Four focus groups were held with WIC participants in four different counties with widely varying geographic and demographic characteristics. The major strength of this focus group method was the role of the groups in directly involving consumers of our services in our needs assessment. The major limitation is that we were unable to conduct as many such groups as we would have liked and we were unable to conduct groups in more varied settings. Between now and the next Title V Needs Assessment, we plan to use focus groups and other methods to better involve more service users in assessing need and in planning programs.

Advisory Group Meetings

Advisory Group meetings were a crucial part of our needs assessment process in both data collection and prioritization. In the first Advisory Group meeting, table discussions related to needs of each population were summarized by a note-taker at each table. Notes from these discussions were used extensively in developing the list of needs for each population that was used for the final prioritization tool (a second online survey).

The major strength of the Advisory Group was in having external partners play an integral role in determining the final priorities to come out of the needs assessment. One main limitation is inherent in the nature of an advisory group, namely that such a group must be limited in size, so some potentially important partners are not included. This limitation was balanced by having much larger numbers participate in the initial survey. Another limitation of our Advisory Group was that we were not as successful as we would have liked in involving representatives of racial and ethnic minority groups and representatives of other groups experiencing need. We plan to work on solutions to this problem in the coming months and years.

Data Book

Our Assessment and Evaluation Unit pulled together data for a set of indicators for each MCH population. The data book was arranged so that its outline matched the final prioritization tool that was used in our needs assessment process. This matching of the data book with the prioritization tool enabled those using the prioritization tool to easily review indicators related to each need for each MCH population as they were prioritizing the needs.

The data book included data from the following sources:

- American Community Survey
  The American Community Survey (ACS) is a survey conducted by the U.S. Census Bureau in every county, American Indian and Alaska Native Area, and Hawaiian Home Land. The survey collects and produces population and housing information on an annual basis. http://www.census.gov/acs/www/

- Block Grant
  Title V Block Grant indicators are reported by every state to the US Department of Health and Human Services on an annual basis. The data underlying the measures and indicators are drawn from a variety of sources. https://perfdata.hrsa.gov/mchb/tvisreports/default.aspx

- BRFSS
  The Behavioral Risk Factor Surveillance System (BRFSS) is an on-going telephone health survey system, tracking health conditions and risk behaviors. Data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. http://www.cdc.gov/brfss/

- CDC Lead Poisoning
  The Centers for Disease Control and Prevention (CDC) Lead Poisoning Prevention Branch (LPPB) compiles state surveillance data for children age <72 months who were tested for lead at least once since January 1, 1997. http://www.cdc.gov/nceh/lead/data/index.htm

- CHS
  The Center for Health Statistics (CHS) is Oregon's vital records office. Each birth, marriage, divorce, and death that occurs in Oregon is registered and filed in CHS.

- Common Core of Data

The Common Core of Data annually collects fiscal and non-fiscal data about all public schools, public school districts and state education agencies in the United States. http://nces.ed.gov/ccd/

- Current Population Survey
  The Current Population Survey (CPS) is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the U.S. population. http://oregon.gov/DAS/OPB/popsurvey.shtml

- Kindergarten Readiness Survey
  Administered to Oregon kindergarten teachers, the Kindergarten Readiness Survey collects data on kindergarten children in most Oregon school districts. http://www.ode.state.or.us/search/page/?id=1356

In addition to data from the above sources, the online data book provided links to sources of data on health disparities.

Final Prioritization Tool

The final prioritization tool was an online survey similar to the initial survey. However, there were two important differences. 1) In the initial survey, women before pregnancy were included in the same population group as pregnant women. Due to feedback in the needs assessment process, these two groups were dealt with as separate populations in the final prioritization tool. 2) The rating scales were different in the two surveys. In the initial survey, there were only 3 points on the rating scale: top priority, medium priority, and lower priority. In the final prioritization tool, an 11-point scale was used: 0 to 10, anchored at both ends and at the mid-point. Furthermore, in the final prioritization tool, respondents were asked to rate each need on 4 different dimensions. The dimensions and anchors are shown in the table below.

Dimension:	Rating Scale		
How much unmet need is there?	0 = No unmet need	5 = Moderate unmet need	10 = Extremely large unmet need
How severe are the consequences of the unmet need?	0 = No consequences	5 = Moderate consequences	10 = Extremely severe consequences
How interested is your community or organization in addressing the unmet need?	0 = No interest	5 = Moderate interest	10 = Intense interest
How large are disparities related to this unmet need?	0 = No disparities	5 = Moderate disparities	10 = Extreme disparities

OCCYSHN Provider Survey and Family Survey (CYSCHN)

The Title V CYSHN program conducted a Family Survey and a Provider Survey to assess the needs of children and youth with special health needs and their families as well as those of community-based providers who serve this target population.

The Family Survey included a combination of Likert scale, multiple-choice and open-ended items. The open-ended items allowed families to elaborate on responses to multiple-choice questions. These responses enriched and personalized survey data and expanded understanding of the unique and diverse experiences, needs, and concerns of families. The combination of quantitative and qualitative information provided a more comprehensive perspective of Oregon CYSHN and their families.

Similarly, the Provider Survey included a combination of Likert scale, multiple choice and open-ended items about their experience and needs relative to working with families and their children and youth with special health needs. Additionally, the survey solicited their perceptions of the needs of families with CYSHN.

Both surveys were administered on-line using Survey Monkey and paper versions when requested. Spanish versions of the Family Survey were available in Survey Monkey and paper. Participants were recruited using multiple marketing strategies including email and direct mail to stakeholder groups, distributing information at conferences and meetings, and posting information on the web. Results were monitored and targeted outreach efforts were made to counties and stakeholder groups where participation was lacking.

Process for Linking Assessment with Priority Selection

The Assessment Leadership Team participated in the interpretation of survey results and participated with "subject matter expert" staff in leading discussions with the Title V Advisory Group. The MCH Assessment and Evaluation Unit provided detailed graphs of survey analysis, showing the frequency of responses for an issue for each population group. The discussions in Title V Advisory Group meetings regarding priorities, barriers, and opportunities, were captured electronically and used as resource information by the Leadership Team in conjunction with prioritization survey results. The MCH Assessment and Evaluation Unit created a summary matrix of all the surveys and meetings that shows the rank of the topic on the scale of priority or need in the surveys and the frequency the topic was selected as a priority in the stakeholder processes. Overall, the quality, validity, and comprehensiveness of the assessment surveys, stakeholder engagement, and evaluation increased the confidence of the Title V Leadership Team that the final priorities for focus by the Title V programs were truly those most important to families and their communities. The selected priorities are slightly outside the usual maternal and child health program area, so the Leadership Team is looking forward to working with community members, families, stakeholders, and state partners to create plans, conduct deeper assessments and implement recommendations appropriate for Title V public health resources.

Dissemination of Findings

The priority goals created by this assessment process will drive planning and resource allocation in the Title V Offices. This five-year needs assessment has created an opportunity to address problems and disparities affecting the health of specific populations and the state as whole. The first year implementation of these goals will be focused on sharing information, initiating new partnerships and collaborations, creating strategic plans and action plans, conducting additional assessment and research, and establishing an ongoing system of surveillance and policy and program development related to each priority goal area.

Title V Offices in OFH and OCCSYHN plan to disseminate the assessment findings and invite continuing participation from families, stakeholders, and partners. The results will be developed into a publication and website for distribution with state and local partners, interested policy and advocacy groups, health and public health professional meetings. Presentations provide an opportunity to learn from the audience about the needs and opportunities related to each priority area. These groups include the Oregon Public Health Advisory Board, the Association of Oregon Public Health Nurses, the Oregon Public Health Association, the Oregon Conference of Local Health Officials, and the Public Health Division Executive Leadership Team, as an example. Presentations or information will be provided to existing groups and meetings focused on the health of population groups, such as women's health, early childhood, adolescent health, and families of children with special health needs. Plans are in place to prepare abstracts on the methodologies and selection of priorities for presentation at national meetings such as the Association of Maternal and Child Health Programs and the MCH Epidemiology Conference.

The Title V Assessment findings will provide the basis for strategic planning around each priority area in collaboration with interested partners, stakeholders and families in both OFH and OCCYSHN. Research into the evidence-based or promising practices based on the assessment findings will help to further define the public health role in addressing broad and difficult social issues such as family violence, mental health, and addictions. This work will drive decisions in the allocation of resources. Additional assessment of disparities or inequities in access to available services or lack of appropriate services will be conducted to determine the need for specific populations and the specifics on reducing disparities through appropriate program and policies.

Overall Process Strengths and Limitations

The primary strength of this five-year assessment was the increased capacity and leadership within the Title V programs in the Office of Family Health and OCCYSHN, especially around evaluation, assessment and leadership. The last assessment concentrated on capacity issues and the outcome was the overwhelming need for evaluation and assessment professionals to be able to better understand the health issues facing the MCH population. This year, the research and evaluation professionals were able to design the MCH Assessment to make sure the priority recommendations were the result of processes that not only assessed the priority needs, but also validated those needs, through surveys and engagement of stakeholders, partners, and consumers. It became clear that even with this additional internal capacity, more was needed to fully assess the disparities related to each of the priority issues and to accurately plan resource allocation; more assessment will be needed around various details surrounding each priority issue.

The Title V programs took the opportunity to invite input through a large integrated forum. This served as a strength to place these issues before a larger audience not traditionally focused on CYHSN; it was challenging to explore and examine the complex array of issues not always readily accessible for consideration by community partners and professionals who may not work directly with CYSHN.

The CYSHN family and provider surveys augmented information regarding complex needs.

The family survey included families with children and youth with diverse medical, behavioral, social, and emotional special health needs from 30 of Oregon's 36 counties. The remaining six counties not captured in the survey were predominately rural-frontier counties with smaller populations. Community-based efforts are underway to explore the needs of CYSHN in these areas. In addition, compared to the 2005-2006 National Survey of CSHCN, the family survey likely oversampled CYSHN with autism.

The primary limitation of the provider survey was the potential bias of the convenience sample. It is unknown the degree to which the sample of survey respondents represents the CYSHN provider population. The survey was a preliminary attempt to assess the needs and practices of providers and their challenges.

For example, the priorities that consistently rose to the top of each step of the process were areas that MCH and public health do not conventionally administer programs – mental health, family violence, and alcohol and drug abuse. Other agencies in the state are lead administrators and are funded to provide interventions and services for persons with these issues. The challenge is to find the role of Title V in helping to alleviate problems or fulfill the needs associated with these issues through the public health perspective and limited resources. In other words, the assessment and priority setting has created a challenge to the programs in engaging stakeholders, engaging new and existing partners, and leveraging Title V resources and funding to implement a role that addresses the MCH population health outcomes associated with these issues.

These priorities reflect more of a social determinants of health framework. They also reflect the significant economic challenges that have plagued Oregon over the last decade. Increasing stress is on families with high unemployment and the subsequent shortages in basic needs and reliability on public services. The dismantling of the mental health system to a community model has inadequate resources. The mental health funding is targeted for chronic and high end use. The opportunity for public health is to focus increases on prevention as there is not funding focused at that end.

2. Partnership Building and Collaboration Efforts

Methods to Build and Enhance Partnerships

Partnerships with state and local agencies and programs are well established in both Title V Programs. Shared planning occurs frequently with local MCH partners through the Conference of Local Health Officials (CLHO), a statutory group of local health authorities to advise and collaborate with the state public health authority, and the MCH Committee of that group, called MCH-CLHO. This group meets monthly around many shared issues and concerns about programs and policies related to MCH services. Title V solicited their input and advice on the Title V Assessment framework, goals, and process. This group helped to gather names for participating in the first on-line survey and in the Title V Advisory Group. They also were major participants in the Child Health Collaborative planning process as well as the Perinatal process in 2008.

The Title V Offices consulted with several state and local agencies to recruit participants in the Title V Advisory Group that would be new to a statewide participatory assessment process and to share any research or information. These included the Office of Multicultural Health, Primary Care Office, and Oregon Health Authority agencies in addition to Public Health Division where the Title V programs are located – Division of Medical Assistance Programs, Addictions and Mental Health Division Programs. Public health programs consulted included the policy staff from the Reproductive and Women's Health Section, Adolescent Health Section and Coordinated School Health program, Injury Prevention and SafeKids program, MCH Section, which has policy staff covering the perinatal through young childhood populations, WIC, and Immunization Section.

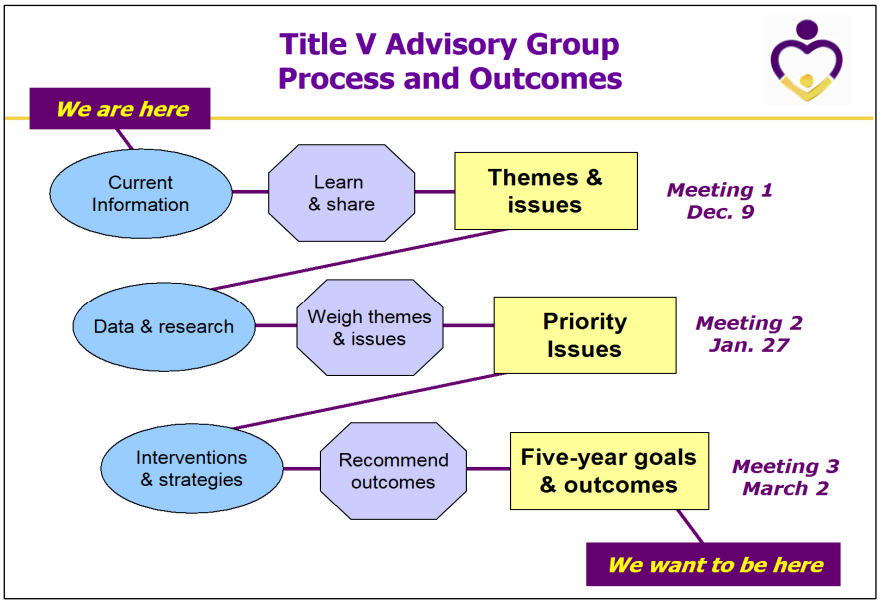
In addition, state and local organizations specifically related to CYSHN, including leaders and clinicians from the Child Development and Rehabilitation Center, family groups focused on meeting the needs of families with CYSHN, family groups from diverse communities, and key Title V CYSHN staff from the CaCoon program, Community Connections program, and Family Involvement program were all consulted throughout the process on identifying priority needs for CYSHN.

Other Public Health programs, such as Chronic Disease, Communicable Disease, and Environmental Health participated in the on-line survey and participated in the Title V Advisory Group meetings.

Stakeholder Involvement

The Title V Advisory Group was the primary source for stakeholder involvement for the purpose of identifying priority health issues facing Oregon maternal and child health populations. The Advisory Group was recruited using formal and informal networks with the Title V offices and the MCH-CLHO Committee. The full roster can be found in Appendix B – Title V Advisory Roster.

Figure 2



The Advisory Group was oriented with reviews of the Title V laws and how Oregon uses the Block Grant resources. Three meetings and processes were planned to make sure that the participants had a chance to air their concerns and ideas early in the process and learn from each other. The first meeting included reviewing the results of the on-line survey and discussing the leading issues from that survey and discussing what they saw as priorities. The second meeting conducted as a webinar included presentation of current data and instructions for the "Prioritization Tool" for the Advisory Group to use to rate the issue areas for each population group using four different scales:

- How much unmet need is there?
- How severe are the consequences of the unmet need?
- How interested is your community or organization in addressing the unmet need?
- How large are disparities related to this unmet need?

The third engagement of the Advisory Group was to finalize their recommendations for priority issues for the state Title V to focus on. Results of the prioritization survey and table discussions for each population group resulted in the recommendations for priorities and a brainstorm of capacity needs, opportunities, and potential partners for each area.

The Title V Offices held an additional step in parallel with the Advisory Group process and helped to validate and clarify the potential role of Title V and public health programs in addressing the issues recommended by the Advisory Group. The same Prioritization Tool was sent to every OFH staff person and several OCCYSHN staff for completion and subject experts within Title V were invited to a meeting to discuss and make recommendations about the priorities that came out of the internal rankings. This internal process engaged staff who will be responsible to carry forth planning, activities, and leadership for the issues and provided a forum to discuss frankly the concerns and ideas about strategies to address those issues. Staff recommendations combined with the Title V Advisory Group recommendations were compiled for decisions about the priorities by the Title V Leadership group.

The Title V Advisory Group Agendas, presentations, data, and other information can be found at http://www.oregon.gov/DHS/ph/ch/mch_advisory.shtml. An evaluation of the Title V Advisory Group process showed overall satisfaction in learning about the topics and providing input and expertise towards selection of the priorities. Universal opinion was that groups experiencing most disparities were underrepresented.

OCCYSHN participated in all the Advisory Group meetings and key stakeholders particularly interested in that population attended these meetings as well. The Family and Provider Surveys were developed in conjunction with multiple stakeholder groups including family members of CYSHN and the input of lead medical specialists in the development of the provider survey. The priorities recommended by the Title V Advisory Group were shared with OCCYSHN staff and leadership to develop priorities and select performance measures.

3. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

The discussion of the strengths and needs of Oregon's MCH populations is based on the data and indicators assembled below to support the leading issues identified through the data collection process. For each population grouping, a brief list of population issues precedes the corresponding data for those issues, and followed by a table of the rankings of those items through the various methods of data collection and prioritization. An explanation of resources for the following data can be found in Appendix 3 and the data book for these data can be found on the MCH Advisory Group http://www.oregon.gov/DHS/ph/ch/mch_advisory.shtml.

Overall Health Status of MCH Populations

Women Before and Between Pregnancies

For the population of women before pregnancy and between pregnancies, the following unmet needs emerged for final prioritization in our needs assessment process:

- Drug and alcohol abuse, including accessibility of services
- Mental health, including accessibility of services
- Healthy eating practices (including use of multivitamins), food security, physical activity, healthy weight / obesity prevention, prevention of diabetes and gestational diabetes
- Accessibility and quality of preconception health care
- Birth timing and birth spacing, including accessibility of reproductive health services and pregnancy prevention among teens
- Oral health, including accessibility of services
- Screening for increased genetic risk and genetic counseling prior to pregnancy
- Family violence, including intimate partner violence and child abuse
- Smoking prevention and cessation
- Prevention of sexually transmitted disease

An overview of information is discussed below regarding the leading unmet needs for women before and between pregnancies.

Drug/Alcohol Abuse

Solid data on drug and alcohol use and abuse in this population is not readily available. However, the PRAMS survey does ask about any alcohol use in the 3 months before pregnancy, and this data indicates that more than half of the women in Oregon (51.7%) and in the US (53.2%) used alcohol in the 3 months before they became pregnant. This fact coupled with the fact that well over a third of pregnancies in 2007 were unintended (Oregon, 39.5%; US, 39.8%) puts fetuses at risk for alcohol exposure.

Mental Health

The Behavioral Risk Factor Surveillance System (BRFSS) provides some self-report data on women's mental health. In 2007, nearly 10% of Oregon women reported that their mental health was not good for 15 or more days of the past 30 days, and 38% reported that their mental health was not good for at least one day of the past 30 days. Additionally, 5% of Oregon women reported symptoms consistent with a major depressive episode.

Access to mental health services is another important issue in Oregon. In 2007, 14.0% of Oregon women reported not having any form of health care coverage, compared with 12.4% of women nationwide who were without coverage.

Family Violence

In 2007, 16.3% of Oregon women reported that at some time during their life someone had had sex with them against their will or without their consent, and 14.1% reported having had injuries as a result of being hit, slapped, punched, shoved, kicked, or otherwise physically hurt by an intimate partner (BRFSS).

Oral Health

Access to dental care is a problem in Oregon. In 2006, 41.6% of women reported not having any type of dental care coverage (BRFSS). Twenty-eight percent (27.8%) of women reported no dental visit in the previous year, and 32.6% of women reported not having a teeth cleaning in the previous year (BRFSS, 2006). Nearly 9 percent (8.9%) of women describe the health of their teeth and gums as being poor or very poor (BRFSS, 2006).

Smoking

In 2007, according to the BRFSS survey, the smoking rate of Oregon women (14.8%) was less than that of US women (18.4%). However, according to the PRAMS survey in 2007, 21.2% of the mothers surveyed had smoked one or more cigarettes on an average day in the 3 months before they became pregnant. Although this is slightly less than the comparable US rate (22.9%), the fact that more than one in five women was smokers just prior to their pregnancy shows a public health need in this area. This need is further compounded by evidence that there is much room for improvement in screening and education by health care providers. According to the BRFSS survey (2007), among women who were current smokers, for 38.3% a health care professional did not advise them to quit during their last visit, and 65.7% were not offered recommendations or assistance on how to quit.

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Women before and between pregnancies	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)	Maternal & Child Health Leadership Retreat (November 2007)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority	
Drug/alcohol abuse / fetal exposure to alcohol and other drugs	1.5	4	4	✓	
Mental health, including accessibility of services / perinatal depression	**	1	2	✓	✓
Family violence, including intimate partner violence and child abuse	1.5	2	1	✓	
Oral health		3	3	✓	
Smoking before and during pregnancy	4				

** This item was not included in the Initial Survey for Women Before and During Pregnancy

Pregnant Women

For the population of pregnant women, the following unmet needs emerged for final prioritization in our needs assessment process:

- Healthy eating practices (including use of prenatal vitamin/mineral supplements), food security, physical activity, healthy weight / obesity prevention, prevention of diabetes and gestational diabetes
- Drug and alcohol abuse, including accessibility of services and prevention of Fetal Alcohol Syndrome
- Mental health, including accessibility of services, and screening / treatment for maternal depression
- Smoking prevention and cessation
- Oral health, including accessibility of services
- Family violence, including intimate partner violence and child abuse
- Pre-term births, low birth weight, infant mortality
- Breastfeeding promotion and education
- Early and adequate prenatal care, including culturally competent, accessible care and eligibility for OHP

An overview of information is discussed below regarding the leading unmet needs for pregnant women.

<u>Drug/Alcohol Use/Abuse</u>

Nearly 9 percent (8.7%) of Oregon mothers reported consuming some alcoholic drinks during the last 3 months of their pregnancy, compared to 6.3% nationwide (PRAMS, 2007). Over 1 percent (1.6%) reported receiving help with an alcohol or drug problem during their pregnancy (PRAMS, 2007). Although most mothers (88.7%) were asked during a prenatal visit if they were drinking alcoholic beverages, a substantial percentage (29.3%) failed to receive education about

how drinking alcohol could affect their baby, and an even greater percentage (38.4%) failed to receive education about how using illegal drugs could affect their baby (PRAMS, 2007).

Mental Health

PRAMS data from 2007 show that 10.5% of mothers reported often or always feeling down, depressed, or hopeless while they were pregnant, and 10.6% reported often or always feeling little interest or pleasure in doing things while they were pregnant.

Family Violence

PRAMS data provides some information about domestic violence during pregnancy. In 2007, 2.9% of Oregon new mothers indicated that they were physically hurt by their husband or partner during pregnancy. This compares with 2.6% nationally. In the same year, 1.5% of Oregon new mothers reported that they received help to reduce violence in their homes during their pregnancy.

Although these percentages are not huge, they may represent under-reporting. In addition, the potential is very serious for life-threatening harm, as well as continued stress and danger for the woman and other family members. After birth, the child's safety may be in jeopardy, and the risk of serious negative psychological effects exists.

At present, there is much room for improvement in the health care system's response to this need. Forty-three percent (42.9%) of new mothers reported that no one talked to them during any of their prenatal care visits about physical abuse to women by their husbands or partners (PRAMS, 2007).

Oral Health

PRAMS data indicate that about half of Oregon pregnant women do not receive adequate oral health care during their pregnancies. In 2007, 51.2% of new mothers reported not going to a dentist or dental clinic during pregnancy, 49.2% had not had their teeth cleaned by a dentist or dental hygienist for 12 months or more, and 51.5% had not had a dental or other health care worker talk with them about how to care for their teeth and gums during pregnancy.

Prenatal Care

In 2007, Oregon's birth certificate data indicated that a sizable percentage (21.6%) of births occurred to women whose prenatal care did not begin in the first trimester. Although in responses to the PRAMS survey, only 10.1% of new mothers indicated that their prenatal care did not start until 13 weeks or more into their pregnancy, 20.0% indicated that they did not receive prenatal care as early in their pregnancy as they wanted.

One problem identified by the needs assessment is that there can be lag time in uninsured pregnant women becoming enrolled in the Oregon Health Plan (Medicaid), which could lead to delays in care. Twenty-nine percent (28.7%) of new mothers report using personal income to pay for some of their prenatal care (PRAMS, 2007).

Smoking

According to PRAMS data in 2007, more than one tenth (10.4%) of Oregon's new mothers reported smoking during their last three months of pregnancy. Although this is lower than the comparable US rate (13.7%), given the potentially serious health consequences, it is a troubling issue. On the positive side, however, 64.6% of smoking women quit smoking during pregnancy and did not begin smoking postpartum.

Pre-term Births, Low Birth Weight, Infant Mortality

In 2006, the percentage of Oregon's live singleton births with a gestation period less than 37 weeks was 6.2%.

In 2008, Oregon's percent of births that were low birth weight (less than 2500 grams) was 6.0%. This is one of the lowest percentages among the 50 states. Nonetheless, there is room for improvement in reducing the percentage further and in eliminating disparities (Medicaid births: 6.5%; Non-Medicaid: 5.7%).

In 2005, Oregon's infant death rate per 1000 live births was 5.9. Although this not a high rate compared with other states, as with low birth weight, there is room for further decreasing the rate and for eliminating disparities.

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Pregnant women	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)	Maternal & Child Health Leadership Retreat (November 2007)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority	
Drug/alcohol abuse / fetal exposure to alcohol and other drugs	1.5	3	2	✓	
Mental health, including accessibility of services / perinatal depression	**	1	3	✓	✓
Family violence, including intimate partner violence and child abuse	1.5	2	1		
Oral health			4		
Early and adequate prenatal care during pregnancy	3				
Smoking before and during pregnancy	4				
Pre-term births, low birth weight, infant mortality		4			

** This item was not included in the Initial Survey for Women Before and During Pregnancy

Mothers and infants

For the population of mothers and infants, the following unmet needs emerged for final prioritization in our needs assessment process:

- Health care for infants, including accessibility of primary care and specialty services
- Broad community supports for families, especially new mothers, including quality infant care
- Infants' health, development, safety, and social-emotional health: Parents' resources and behaviors (including parenting education and other support services)
- Early childhood cavities prevention, including parent education regarding oral health
- Parents' drug and alcohol abuse, including accessibility of services
- Early screening (health, sensory, developmental, social/emotional), referrals, and interventions for infants, including accessibility and coordination of services
- Parents' mental health, including accessibility of services, and screening / treatment for maternal depression
- Family violence, including intimate partner violence and child abuse
- Promotion and support of breastfeeding; infant nutrition, including feeding relationship and introduction of solid foods; and family food security
- Fathers' family involvement

An overview of information is discussed below regarding the leading unmet needs for mothers and infants.

Family Violence

As mentioned above, family violence, including intimate partner violence and child abuse, was rated as a top priority need for several MCH populations in Oregon. Although valid and reliable crime statistics are not readily available, we do have several measures available from PRAMS-2 (2006). While only 0.6% of mothers of 2-year-olds reported anyone having sex with them against their will in the past 12 months, 3.5% reported an intimate partner pushed, hit, slapped, kicked, choked or physically hurt them some other way. Furthermore, 13.8% reported that they received help with a family violence problem in the past 12 months.

These data corroborate the concerns indicated in our surveys and advisory group meetings. Especially in view of the life-threatening potential consequences of violence, and the life course consequences for children who observe or are victims of violence, the fact that domestic violence is not a rare event reinforces the need for action.

Parents' Mental Health

Our PRAMS-2 data (2006) strongly support the emergence of parents' mental health as a priority need. Fully one quarter of mothers of 2-year-olds reported that during the 12 months after their child's birth, they had a period of 2 or more weeks when almost every day they felt sad, blue or depressed for most of the day.

Parents' Drug and Alcohol Abuse

Our PRAMS-2 data (2006) show that while 3.7% of mothers of 2-year-olds drink 7 or more alcoholic drinks in an average week, more than one quarter of mothers of 2-year-olds had at least one occasion of binge drinking (4 or more alcoholic drinks in one sitting) in the past 12 months.

Furthermore, less than 25% of mothers of 2-year-olds report that a health care worker talked with them about how drinking alcohol can affect them.

Parents' Resources and Behaviors for Supporting Healthy Child Development

Although many factors could contribute to infant death rates from injury, those death rates could be considered an indicator of parental effectiveness in keeping their child safe. Oregon's infant death rates from unintentional injuries and from motor vehicle crashes in 2006 were both below the US rates. Nonetheless, unintentional injury is usually the 6th leading cause of infant mortality, so preventive efforts could bring substantial benefits.

Another indicator of parental resources and behaviors is child abuse. In 2007, Oregon's rate of abuse/neglect for children ages 0 to 17 years was 13.4 per 1000 compared with a US rate of 10.6 per 1000.

The National Survey of Children's Health has several measures that more directly assess parents' child-rearing behaviors. In 2007, these indicators were quite similar for Oregon and the US. Some of these indicators show substantial room for improvement for both Oregon and US parents. For example, among families with a TV or video player, the percent of children under 1 year of age who watched TV or videos on an average weekday was 46% for Oregon and 42% for the US. The percent of children under 1 year of age who were not read to by their parent/caregiver or other family member during the past week was 20% for Oregon and 21% for the US.

Early Childhood Cavities Prevention

Most Oregonians (72.6%) reside in areas where they are not using optimally fluoridated water from public water systems. Therefore it is especially critical for parents to be educated about other means to prevent early childhood cavities. However, the PRAMS survey (2007) shows that 67% of new mothers were not spoken with by a health care provider about how to prevent their baby from getting tooth decay. In addition, 78% of mothers of 2-year-olds report that their 2-year-old has never been to a dentist (PRAMS-2, 2007).

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Mothers and infants	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)	Maternal & Child Health Leadership Retreat (November 2007)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority	
Family violence, including intimate partner violence and child abuse	2	4	1.5		
Parents' mental health, including accessibility of services, and screening / treatment for maternal depression	4	1	3	✓	✓
Parents' drug and alcohol abuse, including accessibility of services	2	2.5	1.5		
Skills and resources of parents in nurturing their infant's health, development, safety, and social-emotional health (including parenting education and other support services	2	2.5		✓	
Early childhood cavities prevention, including parent education regarding oral health / preventive oral health			4		

Children Ages 1 to 9 years

For the population of children ages 1 to 9 years, the following unmet needs emerged for final prioritization in our needs assessment process:

- Child care, including quality and accessibility
- Children's social/emotional health, including accessibility of services, and skills / resources of child care providers / schools
- Screening (health, sensory, developmental, social/emotional), referrals, and interventions for young children, including accessibility and coordination of services
- Promoting positive development in all young children in child care, schools, and community settings
- School readiness / success in school (and its relationship with health)
- Young children's health, development, safety, and social-emotional health: Parents' resources and behaviors (including parenting education and other support services)
- Preventing and addressing overweight and obesity in young children, including nutrition, food security, physical activity, and screen time
- Oral health, including accessibility of services - How much unmet need is there?
- Family violence, including intimate partner violence and child abuse
- Resources for the family as a whole, including fathers, grandparents, older siblings, etc.

An overview of information is discussed below regarding the leading unmet needs for children ages 1 through 9 years.

<u>Skills and Resources of Parents</u>

Quite a few measures of parents' skills and resources in supporting and nurturing their young children's development are available, but these measures are frequently somewhat indirect, so it is difficult to paint a comprehensive picture families' needs. Oregon's indicators are similar to those for the US as a whole, with small percentages (under 10%) of indicating such behaviors as no rules about what television programs children ages 6 to 9 are allowed to watch (Oregon 8.3%, US 5.9%) or children ages 6 to 9 years took care of themselves or stayed alone during the past week (Oregon 4.5%, US 4.1).

Although small percentages of parents of children ages 1 to 9 years report fair or poor mental health, it is known that these parental issues can have profound effects on children and families (Fathers with fair or poor mental health: Oregon, 3.3%; US, 4.6%. Mothers with fair or poor mental health: Oregon, 6.1%, US, 7.0%. National Survey of Children's Health, 2007).

According to the National Survey of Children's Health, Oregon parents are somewhat less likely than parents nationwide to report that they have no one to turn to for day-to-day emotional help with parenthood (Oregon, 7.4%; US, 11.4%). Results are mixed for in their neighborhood, people help each other out (Oregon, 4.9% disagree, US, 5.5% disagree), and in their neighborhood, people watch out for each other's children (Oregon, 7.1% disagree, US, 5.3% disagree).

Family Violence

Among Oregon's children ages 0 to 17 years, the rate of victims of abuse or neglect is 13.4 per 1000 compared with 10.6 per 1000 nationwide.

Promotion of Positive Development in Community Settings

A few indicators of community opportunities for young children are available from the National Survey of Children's Health. For these indicators Oregon fares slightly better than the US as a whole. Nonetheless, in 2007, nearly 30% to 50% of Oregon's children either lived in neighborhoods without some kinds of community supports or did not participate in clubs or sports teams. Twenty-eight percent (28.3%) of children ages 1 to 9 years live in a neighborhood without a recreation center, community center or boys' or girls' club. Forty-seven percent (47.4%) of children ages 6 to 9 years did not participate in a club or organization in the past 12 months, and 39.5% did not participate on a sports team or take sports lessons in the past 12 months.

Overweight and Obesity

Oregon's childhood rates of overweight and obesity are alarming, as they are nationwide. For children ages 2 to 5 years who are enrolled in WIC, Oregon's rates of obesity are very similar to those for the country as a whole (Oregon: 14.7%; US: 14.6%) according to an MMWR report (July 24, 2009 / 58(28);769-773).

Many factors contribute to this problem and there is ample data to show where improvements can be made. Just a few examples from Oregon's PRAMS-2 survey are:

- 35.9% of mothers report that their 2-year-old consumes soda pop or other sugar sweetened beverages in a typical week

- 67.9% of mothers report that their 2-year-old consumes french fries at least once in a typical week
- 82.2% of mothers report that their 2-year-old watches television or videos on an average day

Although individual behaviors obviously are important, attention is also turning toward environmental contributors such as food insecurity, neighborhoods without easy access to fresh fruit and vegetables, and neighborhoods without physical activity resources. According to the USDA, based on the Current Population Survey Food Security Supplement, in 2007 12.4% of Oregon's households found it difficult to get adequate food for the household, compared with the US rate of 11.0%. According to the CDC State Indicator Report on Fruits and Veggies, 2009, 21.5% of Oregon's census tracts did not have healthy food retailers within one half mile of their boundaries, compared with 22.0% for the US. The National Survey of Children's Health indicates that Oregon's children ages birth to 8 years are somewhat less likely than US children as a whole to live in neighborhoods without infrastructure that supports physical activity (Percent without sidewalks or paths: Oregon, 20.6%; US 25.6%. Percent without parks or playground areas: Oregon, 13.9%; US, 17.2%. Percent without a recreation center, community center, or boys' or girls' club: Oregon, 29.7%; US 34.7%).

Oral Health

As discussed earlier, Oregon has many problems and needs related to oral health, including lack of water fluoridation, and lack of early oral health care by dental health care professionals. By the time children reach grades 1 to 3, 63.7% have dental caries experience, 19.5% have rampant tooth decay (7 or more dental caries), and 4.1% need urgent dental care (Oregon Smile Survey, 2007).

Child Care

The Oregon Population Survey provides some indications that child care accessibility and quality are problems for the parents of sizable percentages of children. In 2008, the parents of 46% of children 0 to 12 years old reported that their child's child care arrangement was not just what the child needed. Parents of 47% reported that their child care caregiver was not always open to new information, 56% of children do not always get a lot of individual attention in child care, and 19% of children do not always feel safe and secure in their child care setting.

School Readiness

According to Oregon's Kindergarten Readiness Survey, in 2008, from 27% to 38% of children entering Oregon kindergartens did not meet the criteria for various aspects of kindergarten readiness (approaches to learning: 30.4%; cognition/general knowledge: 36.5%; communication, literacy and language development: 38.1%; physical health, well-being and motor development: 26.5%).

Unintentional Injuries

The National Survey of Children's Health for 2007 indicates that 10.9% of Oregon children ages 1 to 5 years had an injury that required medical attention in the past 12 months, compared with 11.8% of children of the same age nationwide. The CDC Web-based Injury Statistics Query and

Reporting System (WISQARS) shows the Oregon death rate per 100,000 unintentional injuries among children ages 1 to 9 years to be 8.2, compared with 7.4 for the US.

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Children ages 1 to 9 years	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)	Child Health Collaborative (March 2010)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority	
Skills and resources of parents in nurturing their child's health, development, safety, and social-emotional health (including parenting education and other support services)	1.5	4		✓	
Family violence, including intimate partner violence and child abuse	1.5	1.5	1.5		
Promote positive development among all young children, including physical and social-emotional health, in child care, schools, and community settings	3.5				
Overweight and obesity (including nutrition, food security, physical activity, and screen time)	3.5	1.5	1.5	✓	✓
Oral health, including accessibility of services /preventive oral health		3	3	✓	✓
Child care, including quality and accessibility			4.5		
School readiness / success in school (and its relationship with health)			4.5		
Unintentional injuries					✓

Older Children and Adolescents Ages 10-24

For the population of children and adolescents ages 10 to 24 years, the following unmet needs emerged for final prioritization in our needs assessment process:

- Preventing and addressing overweight and obesity in older children and adolescents, including nutrition, food security, physical activity, and screen time
- Family violence, including intimate partner violence and child abuse
- Preventing and addressing harassment and bullying
- Prevention of unintentional injuries
- Community resources and activities for youth
- Broad prevention and promotion of general well-being, and engaging adolescents in their own health

- Youth sexual health and education, accessibility of reproductive health services, and preventing and addressing teen pregnancy
- Success in school / educational achievement (and its relationship with health)
- Mental health, including accessibility of services and suicide screening and prevention
- Oral health, including accessibility of care, mouth injury prevention, and prevention of tobacco and substance use
- Access to preventive physical and mental health services

An overview of information is discussed below regarding the leading unmet needs for children and adolescents ages 10 through 24 years.

Teen Pregnancy

The rate of births per 1000 teenagers ages 15 to 17 years was 17.5 in 2008. This puts Oregon's rank among the states on this measure close to the middle.

Alcohol and Substance Use and Abuse

Oregon's Healthy Teens Survey (Youth Behavioral Risk Factor Survey) indicated that in 2007, 27.3% of 11th graders consumed 5 or more alcoholic drinks, consecutively and within a couple of hours, during the past month. The comparable percentage for the US was 29.9%. As with alcohol, for several other types of substances, the 11th grader use rate in Oregon was slightly less than the US rate (Ever smoked a whole cigarette: Oregon 32.7%, US 41.3%; Ever used marijuana: Oregon 18.6%, US 21.4%; Ever used cocaine: Oregon 6.8%, US 7.7%; Ever used methamphetamines: Oregon 4.4%, US 5.4%; Ever used steroids without a prescription: Oregon 2.7%, US 3.1%). However, for some substances and usage measures, Oregon's rates are slightly above the US rates (Use of tobacco, snuff, or dip at least once in the past month: Oregon 8.3%, US 7.6%; Used cocaine in the past 30 days: Oregon 3.1%, US 2.9%; Ever used ecstasy: Oregon 6.4%, US 5.6%; Ever used heroin: Oregon 3.1%, US 1.8%).

These data should be interpreted with caution. Differences between US and Oregon rates may not be statistically significant. Furthermore, when examining multiple measures, as with alcohol and substance use, it is to be expected that sampling error would contribute to some Oregon rates falling above the US rate and other Oregon rates falling below the US rate. Perhaps the most important finding is that substantial percentages of 11th graders use tobacco, alcohol, and marijuana. Although smaller percentages use drugs such as cocaine and heroin, the potential dangers of these drugs add to the importance of the problem.

Youth Sexual Health and Education

In 2007, 45.1% of Oregon 11th graders reported ever having had sexual intercourse, compared with 55.5% nationwide (Oregon Healthy Teens Survey / Youth Behavioral Risk Factor Survey). Substantial percentages of these sexually active teens engage in risky behavior. For example, 21.9% of Oregon sexually active 11th graders reported drinking alcohol or using drugs before their most recent act of sexual behavior (comparable US rate: 21.1%), 39.0% reported that a condom was not used by either partner in their most recent sexual intercourse (comparable US rate: 34.8%), and 19.0% reported that they used no method to prevent pregnancy, used withdrawal, or were not sure if they used birth control (comparable US rate: 22.7%).

Family Violence

In the 2007 Oregon Healthy Teen Survey (Oregon's Youth Risk Behavior Surveillance System), 6.2% of 11th graders reported having been physically forced to have sexual intercourse, and 6.4% reported ever experiencing intimate partner violence. These numbers compare with the US numbers of 8.5% for physically forced to have sexual intercourse and 10.6% for intimate partner violence.

Mental Health

In 2008, Oregon's suicide death rate (per 100,000) among youth ages 15 through 19 years was 10.1. This rate was somewhat over the mid-point in the rank order of states for the measure. Other self-reported measures that come from the Oregon Healthy Teens Survey / Youth Behavioral Risk Factor Survey show Oregon to be very similar to the US as a whole (Percent of 11th graders who have seriously considered suicide in the previous 12 months: Oregon 13.7%, US 13.5%; Percent of 11th graders who have attempted suicide in the previous 12 months: Oregon 6.2%, US 5.8%; Percent of 11th graders who attempted suicide in the previous 12 months and were treated by a doctor or nurse for injury, poisoning, or overdose: Oregon 2.0%, US 1.6%).

The National Survey of Children's Health provides some parent-reported indicators of child mental health. The table below shows these indicators broken down into 2 age groups, as we used them in our needs assessment.

	Ages 10 to 14 years		**Ages 15 to 17 years**	
	Oregon	**US**	**Oregon**	**US**
Percent of children who, during the past month, argued too much	20.4%	21.7%	21.7%	20.6%
Percent of children who, during the past month, felt worthless or inferior	26.1%	19.4%	20.0%	20.0%
Percent of children who, during the past month, were stubborn, sullen, or irritable	10.7%	10.2%	10.8%	10.4%
Percent of children who, during the past month, were withdrawn, and did not get involved with others	16.3%	12.2%	12.5%	14.5%

On these indicators, Oregon and the US are generally very similar, with the possible exception of feelings of worthlessness or inferiority and being withdrawn or not getting involved with others, both for the age group of 10 to 14 years. Nonetheless, the facts that according to parent report, from 10% to 25% of children exhibit these indications of mental health issues; and according to self-report, nearly 14% report seriously consider suicide, show that substantial numbers of youth have needs related to mental health.

Access to Preventive Physical and Mental Health Services

In 2007, Oregon had larger percentages than the US as a whole of children ages 10 to 17 who had no preventive health care visits in the past 12 months (National Survey of Children's Health: Ages 10 – 14 years: Oregon 28.4%, US 16.4%; Ages 15 – 17 years: Oregon 24.5%, US 15.7%).

This is a key need because preventive visits could do much to deal with the other health issues that have emerged in this needs assessment.

One barrier to access is the need for interpreter services and failure to receive them. Results of the National Survey of Children's Health (2007) show that among homes where English is not the language spoken, greater percentages of parents in Oregon report a need for an interpreter to speak with doctors or other health care providers, and larger or similar percentages of those who needed an interpreter never received one (Ages 10 – 14 years in homes where English is not the language spoken: Parents needed and interpreter: Oregon 46.6%, US 29.7%; Needed an interpreter but did not receive one: Oregon, 6.7%, US 2.3%. Ages 15 – 17 years in homes where English is not the language spoken: Parents needed and interpreter: Oregon 51.4%, US 15.5%; Needed an interpreter but did not receive one: Oregon, 11.2%, US 12.0%.).

Results of the National Survey of Children's Health (2007) also reflect problems with referrals and care coordination for this age group. Among parents of children who needed a referral to see a doctor or receive services in the past 12 months, greater percentages of Oregon parents than parents in the US as a whole reported having a big problem getting a referral (Ages 14 – 17 years: Oregon 14.5%, US 8.6%; Ages 15 – 17 years: Oregon, 7.6%, US 4.8%). Among parents of children who used 2 or more services and who felt they could have used extra help arranging or coordinating care, Oregon parents were more likely to report they never got as much help as they wanted (Ages 14 – 17 years: Oregon 49.4%, US 32.5%; Ages 15 – 17 years: Oregon, 44.0%, US 34.8%).

Overweight and Obesity

According to the National Survey of Children's Health, the percentage of Oregon children ages 10 to 17 years who are overweight or obese is 24.3%, whereas it is 31.7% for the US as a whole. Although Oregon's performance is substantially better than the US on this measure, it is obviously undesirable for nearly a quarter of the state's children to be overweight or obese.

As mentioned in the section describing the population of children ages 1 to 9 years, researchers and others are becoming increasingly aware of the multitude of factors that may contribute to unhealthy weight. Family eating practices is one such factor, and the National Survey of Children's Health shows that families of Oregon's children are a little more likely to eat together as a family (Percent of children whose family did not eat at least one meal together on at least 5 days of the last week, with all the family members who live in the household: Ages 10 to 14 years: Oregon 31.7%, US 36.9%; Ages 15 to 17 years: Oregon 42.8%, US 48.5%).

Another factor is the amount of time spent using a computer or watching TV/videos (screen time). According to the National Survey of Children's Health (2007), Oregon youth spend slightly less time than their US counterparts; however, they still spend well over 2 hours on an average weekday, not including computer time for school work (Average number of minutes spent using a computer for purposes other than schoolwork on an average weekday: Ages 10 to 14 years: Oregon 64.8 minutes, US 66.4 minutes; Ages 15 to 17 years: Oregon 87.4 minutes, US 101.4 minutes; Average number of minutes spent watching TV, watching videos or playing video games on an average weekday: Ages 10 to 14 years: Oregon 101.1 minutes, US 112.3 minutes; Ages 15 to 17 years: Oregon 110.1 minutes, US 117.5 minutes).

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Older children and adolescents ages 10-24	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority
Teen pregnancy	1.5			
Alcohol and substance use and abuse	1.5			
Youth sexual health and education / accessibility of reproductive health services	4.5		4.5	
Family violence, including intimate partner violence and child abuse	4.5	2.5	1	
Mental health, including accessibility of services and suicide screening and prevention	4.5	1	3	✓
Access to preventive physical and mental health services	4.5	2.5	4.5	✓
Overweight and obesity in older children and adolescents, including nutrition, food security, physical activity, and screen time		4	2	

Children and Youth with Special Health Needs (CYSHN)

For the population of children and youth with special health needs (ages 0 to 21 years), the following unmet needs emerged for final prioritization in our needs assessment process:

- Opportunities to receive health and mental health consultation regarding care of children and youth with special health needs
- Knowledge, skills, and confidence of parents in caring for children with special health needs
- Mental health for families and children
- Geographic limitation of many specialized services to metro areas Respite and qualified child care / after-school programs
- Transition to adult life, including adult health services, work and independence
- Respite care availability for caretakers
- Gaps in early childhood services
- Collaboration across health, social and support services for children and youth with special health needs
- Access to adequate health care insurance coverage

- Information and navigational supports - including care coordination, case management, information that is in usable and accessible forms
- Financial supports - items not covered by insurance or other means
- Accessibility of health, social, and support services
- Communication between schools and services (physical and mental health services and other services)

Few data sources are available to determine a broad range of unmet health issues. The 2005-06 National Survey of Children with Special Health Needs (NS-CSHCN) is the most current national resource for understanding the issues for unmet needs for this population. Information from the NS-CSHCN estimates that 10.2 million children and youth nationwide had special health needs with a prevalence estimate from 10 percent to 18.5 percent. That translates to one in five households or 8.8 million households nationally. Applying the national prevalence estimate of 13.6% to Oregon, approximately 132,796 Oregon children and youth have a special health need. Nearly 6 % of these children have a condition that significantly interferes with day-to-day activities. CYSHN are more likely to be male (59% v 50%) and older (12-17 years) compared to children not meeting CYSHN criteria. CYSHN are equally likely to live in low income families.

CYSHN account for 40 percent or more of medical expenditures among all children although they comprise about 14 percent of the child population. CYSHN are three times as likely to visit an emergency room 2 or more times than other children (13% v 4%). The health status of CYSHN is worse than other children. About 10 percent of CYSHN report fair or poor health compared to only about 2 percent of other children. CYSHN miss 2 or more weeks of school at a rate of 14 percent compared to 3 percent for other children and are more likely to repeat a grade in school (18% v 10%). CYSHN parents are contacted more frequently about problems at school (37% v 14%).

The priorities identified by the Child Health Collaborative and the Title V CYSHN Family and Provider surveys were largely consistent with those raised in the Title V Advisory Group, validating these as areas to help focus the state's Title V resources. The Title V CYSHN Family and Provider Survey results identified greatest needs of families and their children to include respite care, care coordination, specialized care such as speech and occupational therapy, specialty care, and mental health services. Providers identified financial resources, respite care, and care coordination as the greatest needs of CYSHN.

The following table shows the needs that were ranked among the top 4 in any of the surveys or were chosen by an advisory group as a priority.

Children and youth with special health needs (CYSHN)	Initial Title V Needs Assessment Survey (Summer 2009)	Title V Needs Assessment Advisory Group Survey (February 2010)	OFH Staff Survey (March 2010)	Title V Needs Assessment Advisory Group Final Meeting (March 2010)	Maternal & Child Health Leadership Retreat (November 2007)	Child Health Collaborative (March 2010)
	Rank order of item on scale of priority or need (1 is top priority or most need)			Check indicates the item was selected by the group as a top priority		
Access to adequate health care insurance coverage	1		2			
Knowledge, skills, and confidence of parents in caring for children with special health needs	3.5		4			
Accessibility of health, social, and support services for children and youth with special health needs	3.5					
Mental health of families and children with special health needs	3.5	1	1	✓	✓	
Opportunities to receive health and mental health consultation regarding care of children and youth with special health needs	3.5	2.5				
Geographic limitation of many specialized services to metro areas		2.5		✓		
Respite and qualified child care / after-school programs		4.5	3			
Communication between schools and services (physical and mental health services and other services)		4.5				
Oral health, including accessibility of services /preventive oral health						✓
Unintentional injuries						✓
Obesity/physical activity						✓

4. MCH Program Capacity by Pyramid Levels

Stakeholder input included brainstorms about barriers and opportunities to address the top priority issues raised in the Title V Advisory Group meetings and the surveys conducted by both the OFH Title V Program and the OCCSYHN Program. As part of the next steps in addressing the priorities, more in depth capacity assessment specific to each priority will be conducted, with particular emphasis on the disparities and inequities in capacity.

Direct Health Care Services

Needs:

Disparities or inequity in access to health services is apparent for all populations, and particularly for families of color, immigrants with resident children, and all persons living in rural and isolated areas, particularly for families with children with special health needs. In both urban and rural/frontier communities, there is a particular deficiency in available mental health and dental

health services and providers. Services are needed that meet the traditional or transitional needs of those who are non-English speaking, non-white, have little or no health insurance, and/or living in rural and frontier areas of the state. Public funding or support, combined with untrained health and service providers are needed to begin reducing these disparities and inequities in access to medical, dental and mental health care access. The Oregon Health Professional Shortage Areas (HPSA) show that Oregon has 102 primary care HPSAs, 76 dental care HPSAs, and 54 mental health HPSAs. (http://www.oregon.gov/DHS/ph/hsp/hpshortage/index.shtml)

Oregon geography presents a significant barrier to obtaining care where the mean travel time is 23.7 minutes in rural Oregon, with several areas taking up to an hour or more to the nearest hospital facility. The distance to services is especially difficult for reaching specialty care needed by CYSHN and their families. Specialty care is concentrated in urban areas, predominantly in Portland. There is little or no specialty care services in the rural or frontier counties, where the existing providers are not adequately trained to provide care for CYSHN.

With mental health wellness a major concern across the MCH populations, not only is access at issue but also availability of age-appropriate, family-centered, culturally appropriate services. The community mental health system meets only 46 percent of the need, and many providers are not trained in screening of young children for social-emotional and behavioral problems or for maternal depression disorders. Improvement in availability of preventive screening, referral sources, care coordination and management, and treatment, particularly by pediatric providers, is needed for preventable and manageable mental health conditions. Input by stakeholders included a need for mental health services that are integrated or co-located with primary care service delivery, that meet the language and cultural norms of all persons needing care. Mental health consultation for pediatric primary care providers and for families of children and youth with special health needs would help to bridge primary care or community services who have inadequate access to mental health specialists. Access is also a problem for new mothers may lose coverage on the Oregon Health Plan two months postpartum, and therefore lose the ability to continue treatment for maternal depression, if needed. Flexibility in the policies regarding coverage of the mother as it relates to the early development of the child is needed to prevent the negative effects of maternal depression and other behavioral and mental health disorders.

Dental health care is a concern, especially for pregnant women and very young children. Prenatal and pediatric health care providers are not trained or confident in screening pregnant women for oral health diseases, and dentists are reluctant to serve under/uninsured women and children. Stakeholders reported a need to assure fluoride varnish is applied in well-child visits and to provide dental insurance or care up to six months postpartum for pregnant women, where the Oregon Health Plan currently covers dental care for pregnant women through two months postpartum. Oregon citizens have a long history of advocating, as well as opposing fluoridation of community water systems and this issue continues to be a high priority for optimal prevention of early childhood cavities.

Strengths and Opportunities:

The needs identified for direct services are preventive or are early interventions that prevent associated conditions across the individual's lifetime. Opportunities to build capacity in direct

services was identified by the Title V Group and will help guide additional capacity assessment and planning for each of the priority areas.

- Expansion of public health nurse home visiting services
- Full service public health clinics such as Federally Qualified Health Centers
- Expansion and increased familiarity with the services of School Based Health Centers
- The Oregon Wraparound demonstration will improve services across the state, particularly for children with high mental health needs, particularly those with frequent contact with foster care and mental health services
- Boosting capacity of MH providers and payment system is competitive for Medicaid
- Dental care programs to reach pregnant women and infants, including children with special health needs, will increase preventive care and awareness

Enabling Services

Needs:

Community-based supports and coordination of services are needed to assure MCH populations are able to reach available services. Parents need access to information, training, skill-building and support systems that help them nurture and support the developmental and emotional needs of the young child in all families. Resources and mentors for parents, including fathers, are needed to assure children have the attachment and bonding needed for optimal social emotional health. Families of CYSHN in particular have complex social, emotional, medical, and financial needs. Family support and resources and help these families address these needs and better navigate through the systems of care. Cultural competence in all aspects of service delivery is especially important as Oregon demographics shift to more first and second generation immigrant families.

Adequate resources in the community, at schools, and at worksites are needed to bridge gaps and inequities for linking families to information and services they need to establish healthy and safe families. Outreach can be more effective by using natural supports, such as faith organizations, apartment buildings, and community organizations, to connect to needed physical, dental, mental, and specialized services. Statewide home visiting services and supports need to improve policy and program coordination at the state level to better support outreach and linkages for clients to appropriate resources and programs.

Strengths and Opportunities:

The needs identified for enabling services are focused on reducing the gaps in services inherent in Oregon's rural/frontier geography and the need to include extended family members not traditionally part of the federal MCH population definitions. Opportunities for enabling services identified by the Title V Group will provide foundations for continuing assessment and planning around each of the priority health issues.

- Use of computer-based social networking, interactive websites, and 211-Info will improve access to information, referrals and family supports
- The Portland housing authority is participating in an STD prevention collaborative with the county public health department; collaborations with public housing provides opportunities for other collaborations for reducing family violence, alcohol use, and increasing access to resources for positive parenting

- Supporting men who are fathers or potential fathers for parenting skills and information is a growing trend in some existing public health and mental health services
- School-based Health Centers include the resources and referrals for parents and children
- Restructuring of the home visiting system in Oregon will improve the coordination and referrals based on the risks and needs of the parents and their children
- Preventive health information and parenting resources in worksites could be improved as the new Oregon Health Authority includes agencies that work through partnerships with private employer health plans
- Healthy Kids insurance plan that covers all children with insurance, either through the Oregon Health Plan or subsidies for co-pays or employer premiums, provides an opportunity to share health promotion messages and resources to families and employers
- Increase linkages between the rural community-based CCN program and local mental health system

Population-Based Services

Needs:

Stakeholders raised concerns about the limited protective community practices and preventive health care services available to reduce behaviors and conditions that increase risk and safety among families. These include community practices about healthy choices for food and exercise, and preventive services that support healthy mental and physical health conditions. Messages and information about mental health wellness and services could be improved to reduce stigma among those needing mental health services. Increased understanding and awareness by community organizations, schools, health, and service providers is needed to improve community-based investments that support prevention of intimate partner or domestic violence, early brain development and parent-child interaction, as well as healthy food choices and exercise.

Preventive screening of children and adolescents should occur where they are, such as child care, Head Start, and schools to identify CYSHN and link them to appropriate resources and services.

Communities need to be plan and build environments that support families, pregnant women, fathers, and children and youth with special health needs. Communities can be built so that healthy choices are the easy choices for children, youth, and their families. Social marketing and health education that is cultural appropriate could increase healthy choices limiting access to sweetened beverages for children under five years old, increasing affordable and available fresh fruits and vegetables, and reducing TV or computer screen time for all children.

Public education and awareness is needed to increase preventive physical, dental, and mental wellness screening of children and adolescents, perhaps by increasing screening in locations where these populations are located during the day, like schools and child care centers.

Community-based health promotion would increase the understanding about local practices that can prevent preventable communicable and chronic diseases, including cavities and obesity and overweight conditions. Adolescent-friendly settings are needed to provide affordable and comprehensive physical and mental health services, as well as support and promotes positive

youth development. Culturally appropriate education and discussion about sexual health behaviors is needed to increase acceptance among diverse populations and settings.

Strengths and Opportunities:
Population-based services cover the promotion of preventive practices and activities that can be implemented by communities appropriate to the diversity of their own populations. Stakeholders suggested opportunities that provide healthy choices and health education in neighborhoods, worksites, and educational and faith institutions. Programs currently in some communities could be expanded statewide to reach more populations or adapted to reach those communities experiencing disparities. Population-based opportunities identified by the Title V Group will guide additional capacity assessment and planning.

- Farmer's Markets provide fruits and vegetables as well as health education and referrals to community services
- Engage the elderly community in MCH health messages; educate and raise awareness about preventive practices such as breastfeeding, infant back-to-sleep, community gardens, and healthy food preparation
- Engage employers, promote working environments that support pregnancy, breastfeeding mothers, and healthy eating and exercise
- County health departments are beginning to collaborate better across/between urban-rural areas to increase health promotion and education, as well as collaborative services
- Engage families to improve attachment and bonding to increase health of parents and children, provide resources and education about whole family activities

Infrastructure and Systems Building
Needs:
Oregon's infrastructure and systems have gaps, strengths, and emerging activities that address the concerns and needs across all MCH populations, though disparities continue to exist within the systems of health care and community-base prevention services. Additional capacity assessment is needed to determine where and how to address the gaps and barriers in Oregon's system of services for the MCH populations. From the stakeholder input, the overriding need in statewide or community infrastructures and systems was the lack of cultural and linguistic appropriate services that are linked or coordinated with the established services and providers, especially for mental health and preventive physical and dental health services. A critical need is for integrated and more effective care coordination throughout the health services and preventive care delivery system. An effective system that is responsive to the community it serves is needed to increase access to appropriate and comprehensive mental health services, dental health services, and preventive physical and developmental services. State policies and professional practice standards could mandate that interpretive and language services are always available in service delivery in all parts of the state. Resources in funding and in expertise are needed assist communities in building safe neighborhoods with readily available walkways to schools, physical activities, and healthy choices in food.

Training and continuing education for the health and community service providers is needed to increase knowledge about delivery and care coordination for MCH populations, particularly for young children and children and youth with special health needs. Service and health providers

need culturally appropriate training in preventive screening for women and pregnant women for depression, oral health, tobacco/alcohol and drug use, intimate partner violence, and appropriate weight. The statewide infrastructure could invest resources in to support community efforts to build systems that provide linkages and coordination among services and referral sources and delivery of health and health related services.

The expanded use of technology, such as electronic health records, will effectively coordinate and provide more efficient health services wherever people access those services. Technological options are underused in Oregon, particularly in rural and frontier areas where connectivity continues to be a problem. Access to specialists and health consultants through on-line video discussions would greatly enhance the availability of services appropriate to the need of individuals and families. Training and increased connectivity is needed to increase the use of technology in rural and frontier areas as well as with populations experiencing disparities caused either by geographic or ethnic isolation.

Strengths and Opportunities:
The MCH system of services and supports for families has many opportunities both through existing efforts and resources to build infrastructure and through local initiatives or demonstrations that can be expanded to other communities. Stakeholders suggested opportunities for improved infrastructure are found in maximizing technology conveniences, conducting assessments and surveillance to better define problems and interventions, and investing resources in systems or methodologies most efficient to addressing the issues. Opportunities for building infrastructure in several areas were identified by the Title V Group and this list guide additional capacity assessment and planning.

Technology, data collection, surveillance

- Engage youth and parents using social media and texting to share health promotion and education messages
- Explore using Skype or other on-line camera communications to consult and train providers and parents in preventive services or expertise
- Integrate state data requirements and systems to reduce the program data entry into multiple systems by local programs, such as a data warehouse
- Implement system of community-based participatory research to identify evidence-based and best practices, and disparities in services
- Create surveillance of health status using data we have

Provider standards and policies

- “Integrated health home" policies recommended by the Oregon Health Funding Board will improve linkages between physical and mental health services
- Training for early childhood health providers in standardized screening for developmental delays by the Oregon Pediatric Society (START) is expanding to maternal depression and oral health screening
- Guidelines for child care and schools are transitioning to "whole kid" messages

Partnerships

- Community coordination around domestic violence, such as convening a collaboration of state public-private groups, Governor's Office, and prevention services
- Establish partnerships to support the health and development of young children and their parents with athletic and sports corporations
- Programs or initiatives are being implemented that support lifespan approach to intervention (LAUNCH grant); physical activity ("Just Move" – Michelle Obama campaign); and "We Can!" - hunger relief campaign
- Raise awareness and increase partnerships with Family Voices for families with children and youth with special health needs
- Train families in advocacy for community coordination and delivery of services that are family-centered, culturally competent, and community-based, for all children as well as children with special health needs
- Increase partnerships in program and policy development with other state agencies to improve delivery and coordination of local services, such as home visiting and teen pregnancy prevention

Funding

- Leverage funding and resources to create opportunities in schools for health services that are not School-Based Health Centers
- Encourage state and county partnerships in planning for public health and mental health federal grants
- Leverage health reform to propose changes in reimbursement rates for public health clinics and preventive well visits by both public and private providers
- Support workforce development of providers and leadership to improve recruitment and retention of the health workforce
- The Healthy Schools mental health grant in Klamath Falls could be replicated in other communities

Statewide Policy

- Improvements in addressing maternal depression by health and service providers should be improved with the publication of the Maternal Depression Task Force Recommendations (September, 2010)
- Policies that may improve the overweight/obese health status of children and adolescents such as eliminating sweetened drinks and sodas from schools/businesses/public spaces
- The new Oregon Health Authority organization has public-private partnership opportunities to develop and implement preventive health practices, standards, and education through public-
- Increased dependent age to 24 for health insurance by federal health reform is an opportunity to assure preventive health care for that age group
- Training, resources and incentives for primary care providers to increase knowledge and practice of prevention and local referral resources for all children and families, as well as children and youth with special health needs; opportunities for training exist through academic health professional programs and in hospital grand rounds.

OCCYSHN worked collaboratively with OFH, the CDRC Clinical program, the Oregon Office on Disability and Health, Oregon Pediatric Society, Juntos Podemos and Family Voices throughout the overall Oregon Title V Needs Assessment process. OCCYSHN engaged its community-based partners in providing input into the needs assessment process through invitations to the Title V Advisory Group and the needs assessment surveys. Simultaneously, the OCCYSHN office conducted a more detailed examination of the needs of its targeted population – children and youth with special health needs and their families and the providers who serve this population at the community level. Surveys were disseminated throughout Oregon's health system, including private providers and other community-based providers, as well as providers across multiple service systems.

OCCYSHN identified family organizations and families to provide input and participate in needs assessment planning efforts. With that input, the OCCYSHN Family Involvement Network program staff assessed family involvement within OCCYSHN and its related systems of care activities as indicated in the Block Grant's self-rating of family participation in CSHN programs (Form 13).

5. Selection of State Priority Needs

Potential Priorities

In Section 3, the total list of priorities is listed for each population group along with tables showing the rankings and selections by the various assessment processes. With the phased survey and prioritization methods, the selection of the priority health needs was straightforward. The Title V Leadership Team reviewed the summary report prepared by the assessment team, consulted the needs and priorities collected from stakeholders, reported in Section 4 above. The Leadership Team then used the following criteria for selecting the final priorities and goals.

- Level of rankings across all processes for a specific population group
- Existing or potential of working on the issue by the Title V Offices
- Ability to influence change in a measure with activities conducted or leveraged by the Title V Office in both agencies
- Leadership for the priority area is handled in another sector or state agency

The challenge with selecting priorities are that many of the issues are rooted in problems related to social determinants of health like poverty, employment, education, health care access, and language or cultural differences. Balancing the expressed need with the scope and current uses of Title V resources presented the greatest challenge in deciding on final priority goals for action.

Nevertheless, the Leadership Team was committed to staying true to the findings of the comprehensive assessment processes, and made decisions on goals that could reasonably be addressed by the Title V Offices. The table below lists all the needs considered for the ten Title V goals. These are organized by population life-course to emphasize the intent to select goals with interventions that have the most positive effect across the life course.

Summary of Priorities -- 2010 Title V Needs Assessment and Related Activities

	Women Before Pregnancy and Between Pregnancies	Pregnant Women	Mothers and Infants	Young Children	Older Children and Adolescents	Children / Youth with Special Health Care Needs
Drug/alcohol abuse / fetal exposure to alcohol and other drugs	✓✓✓✔	✓✓✓✔	✓✓✓		✓	
Mental health, including accessibility of services / parent mental health / perinatal depression / child and adolescent social-emotional health / suicide prevention	✓✓✔	✓✓✔ ✔	✓✓✓✔		✓✓✓✔	✓✓✓✔
Family violence, including intimate partner violence and child abuse	✓✓✓✔	✓✓✓	✓✓✓	✓✓✓	✓✓✓	
Oral health, including accessibility of services /preventive oral health / early childhood cavities prevention	✓✓✔	✓	✓	✓✓✔ ✔		
Early and adequate prenatal care during pregnancy	✓	✓				
Smoking before and during pregnancy	✓	✓				
Preconception health	✔					
Skills and resources of parents in nurturing their child's health, development, safety, and social-emotional health (including parenting education and other support services)			✓✓✔	✓✓✔		✓✓
Unintentional injuries				✔		
Overweight and obesity (including nutrition, food security, physical activity, and screen time)				✓✓✓✔ ✔	✓✓	
Youth sexual health and education / accessibility of reproductive health services					✓✓	
Access to preventive physical and mental health services					✓✓✓✔	
Geographic limitation of many specialized services to metro areas						✔

Key: ✓ = Ranked among the top 4 to 5 needs one of the three Needs Assessment surveys

✔ = Recommended by an advisory group as a top priority

**Note: In order not to over-weight the Maternal & Child Health Leadership Retreat and the Child Health Collaborative, a large checkmark for each of their selected priorities is indicated for only one population [Preconception health: Women Before Pregnancy and Between Pregnancies; Perinatal depression (mental health): Pregnant Women; all of the Child Health Collaborative priorities: Young Children].

Methodologies for Ranking Selecting Priorities

The selection of the priority goals by the Title V Leadership Team was determined by the rankings presented from the stakeholder surveys and the stakeholder meetings. The assessment process goal was to select ten goals and measures. Once the discussions eliminated some of the issues already addressed by Title V programs, there were ten issues left on the list. The prioritization from many issues and discussions had accomplished the selection of priority goals. The ten goals are:

1. **Family Violence –** Family violence, including intimate partner violence and child abuse

2. **Alcohol and Drug Use –** Drug and alcohol abuse, including accessibility of services (and prevention of Fetal Alcohol Syndrome)

3. **Mental Health –** Mental health, including accessibility of services

4. **Oral Health –** Oral health and early childhood cavities prevention, including accessibility of services

5. **Resources for Parent Education and Skills –** Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health

6. **Overweight and Obesity** – Prevent and address overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time

7. **Physical and Mental Health Services Access –** Access to preventive physical and mental health services

8. **Linkages for CYSHN to Mental Health Services –** Lack of linkages or referral pathways to appropriate mental health services for children and youth with special health need

9. **Access to Specialized Services –** Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas

10. **Access to Family Support Services –** Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need

Priorities Compared with Prior Needs Assessment

The Oregon Five-Year Assessment found some priority needs continuing and others emerging more prominent. The need for better access and more culturally appropriate services continues to be a problem in many communities and among populations, such as access and referral systems to mental health services for all population groups, preventive oral health services, and healthy weight and physical activity. Emerging areas in the 2011 assessment include more critical and difficult issues, such as family violence, and alcohol and drug abuse. For these areas, more research, assessment, and planning is necessary to identify those actions and roles for public health to influence a positive health outcome in a generally social justice issue.

In 2006, priorities were more focused on public health and Title V program capacity, with a need for strengthened leadership and surveillance and assessment. The Title V programs have accomplished the capacity goals and the Title V Agency has more internal capacity than five years ago. The cross-cutting priority to improve surveillance of disparities of subpopulations was not accomplished, as the capacity for assessment and surveillance needed to be established first.

2006-2011 Oregon Title V Priorities and Performance Measures

Priorities and Goals	Measures
Children's health needs are always met.	
▪ *Improve early child development and access to early intervention services as measured by the percent of infants diagnosed with hearing loss that are enrolled in early intervention before 6 months of age.*	SPM #2: Percent of infants diagnosed with hearing loss that are enrolled in Early Intervention before 6 months of age
▪ *Improve the access of well-child care as measured by an increase in the percent of children that complete the 4th DTaP vaccine between 12-18 months of age.*	SPM # 4: Percent of children that complete the 4th DTAP vaccine (12-18 mos)
▪ *Decrease the percent of 11th graders who report having unmet health care needs*	SPM # 5 Percent of 11th graders who report having unmet health care needs
Individuals and families exhibit healthy lifestyles	
▪ *Improve oral health by increasing the percent of Oregonians living in a community where the water system is optimally fluoridated*	SPM #7: Percent of Oregonians living in a community where the water system is optimally fluoridated
▪ *Reduce low birthweight and improve the health of women and their newborns by increasing the percent of smoking pregnant women who quit smoking during pregnancy and continued quit after pregnancy.*	SPM #2: Percent of smoking pregnant women who quit smoking during pregnancy and remained quit
▪ *Improve the health of children and families as measured by the percent of births that are intended.*	SPM #1: Percent of births that are intended
▪ *Increase the percent of adolescents engaging in physical activity as measured by the percent of (8th and 11th) graders who report 3 or more days of vigorous physical activity in the last 7 days*	SPM # 5: Percent of 8th graders who being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days
Parents and providers are confident in caring for children	
▪ *Improve the care of children with special health needs by increasing the percent of health care providers who report confidence in caring for CYSHN and their families*	SPM #8: Percent of health care providers who report confidence in caring for CYSHN and their families.
▪ *Improve access to care for children with special health needs by increasing the percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.*	SPM # 9: Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.
▪ *Increase the percent of families of CYSHN who reside in rural areas who report that needs are usually or always met.*	SPM # 10: Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.
Children, adolescents and families experience optimal mental health and social emotional development.	
▪ *Improve mental health and social emotional development of mothers, children and adolescents*	Developmental; No state measure
Racial and ethnic disparities are eliminated (cross-cutting)	
▪ *Improve surveillance of priorities by race, ethnicity and other sub-populations*	No state measure
Strong leadership is helping to reduce morbidity and mortality of the maternal and child health population (cross-cutting	
▪ *Improve collaboration systems, program evaluation capacity, and use available data information for state and community profiling and advocacy.*	No state measure

With a unit and staff firmly in place, this priority will continue and a plan is in place to conduct research and assessment in the context of the new priority areas. For the mental health topic area five years ago, the Title V Assessment identified mental health as an issue, but without an identifiable data source to create a performance measure. Activities in the intervening years included policy-changing activities particularly around screening for perinatal depression and for early childhood developmental and social-emotional delays. With these activities just beginning, this year's assessment includes two measures with reliable data sources that can track progress in meeting the needs expressed for these population groups. Overall, the Five-Year Needs Assessment is an opportunity to celebrate accomplishments and gather information to focus on new challenges.

2011-2016 Oregon Title V Priorities and Performance Measures

Goal	State Performance Measure
Improve Oregon's systems and services for screening women for domestic and sexual violence (DSV) and for linking those affected by DSV to adequate services	1. Percent of family planning clinic encounters in which relationship safety was discussed with the client. (Ahlers Family Planning Client Data-Oregon)
Decrease the risk of lifetime dependence on alcohol for teens and adults	2. Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of beer, wine, or hard liquor for the first time (Oregon Healthy Teens Survey)
Improve Oregon's systems and services to identify, treat and support women with perinatal mental health disorders and support their infants and families	3. For all Medicaid clients with an expected delivery date during the calendar year, percent who were screened for depression during the time period from 9 months before delivery to 9 months after delivery. (Division of Medical Assistance Programs - Medicaid/Oregon Health Plan claims)
Increase the percent of children under 3 years old who have a preventive dental visit each year	4. Percent of children on Medicaid ages 0-3 years with a preventive dental visit in the year. (Division of Medical Assistance Programs - Medicaid/Oregon Health Plan Claims)
Improve the state's capacity for supporting parents in building parent skills and for linking parents to resources by improving the breadth, depth, and coordination of the home visiting infrastructure.	5. Using benchmarks, develop a strategic plan for the MCH public health role and responsibilities in parent education and skills development within the context of the Early Childhood Comprehensive Systems work. Benchmarks are: a) An MCH workgroup including local and state partners is convened to define the role of MCH in building parent resources for desired child health outcomes (as identified by Title V and Early Childhood Matters Council and Committees) b) Existing planning efforts and parent resources are identified in relationship to the desired child health outcomes c) A statewide needs assessment is conducted to supplement existing knowledge tied to identified child outcomes and further define the role MCH can play in developing better resources for parent education and skill development. d) MCH in collaboration with the Early Childhood Matters and ECCS develop a strategic plan that clearly defined roles/responsibilities for MCH programs and staff related the specific child health outcomes and performance measures tied to parent resource development. (Source: New survey and program records)
Increase the percent of children/adolescents with a healthy body weight	6. Percent of 8th grade students with a BMI below the 85th percentile. (Oregon Healthy Teens)
Increase access to preventive physical and mental health services	7. Percent of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months. (Oregon Healthy Teens).
Increase linkages to mental health services for children and youth with special health needs	8. Among CYSHN who needed mental health/counseling, percentage of CYHSN who received all needed care. (Source: National Survey of Children and Youth with Special Health Needs
Increase access to specialized health and related services for underserved populations of children and youth with special health needs.	9. Among CYSHN who needed specialized services, % of CYHSN who received all needed care. (Source: National Survey of Children and Youth with Special Health Needs
Increase access to family support services for families of children and youth with special health needs	10 Progress in implementing a comprehensive strategic plan to address family support needs for Oregon families of CYSHN. (Source: OCCYSHN Strategic Plan to address family support needs)

Priority Needs for MCH Populations and Capacity

In the Oregon assessment, the selection of priorities evolved over the course of the assessment with input from surveys and from stakeholder engagement. As some of the priority areas were pertinent to more than one population group, the Leadership Team determined to select one population group to focus that priority need.

Mental health, in particular, was the most consistently identified priority need among all population groups. The discussion on how to address mental health in the Title V context centered on the fact that mental health problems are very closely linked to family violence and alcohol use, as well as depression and early childhood and adolescent developmental and behavioral needs. Other agencies and initiatives are in place to address many of these issues. By looking at the life-course of an individual and the effectiveness of potential interventions that prevent other problems exponentially worsening, addressing mental health of the mother and infant seemed the best choice. Added to that reasoning is the fact that significant work in state policy, provider training in screening and referral, and new home visiting structures, the decision for selecting maternal depression prevention as a priority goal was the best choice for Title V.

Decisions for selecting priorities around family violence and alcohol addiction followed the same course. These two issues were identified as largely preconception issues that had been identified by previous assessments and shared planning with state and local partners. The opportunity was in the existing program work within the Office of Family Health in family planning clinics and in adolescent health education and preventive visits. Evidence showed that girls and young women benefit from education and awareness in relationship safety before or early in sexual relationships. Evidence is also clear that alcohol use before the age of 14 is a predictor of life-time dependency, so prevention before age 14 would be most beneficial. Goals in these areas are targeted towards teen and young women. Selecting these two issues made it unnecessary to select the topic of "preconception health," which was too unspecific for a priority goal and, in fact, family violence prevention and alcohol use prevention are both preconception health topics.

The priorities for early prenatal care, smoking during pregnancy, youth sexual education, and unintentional injuries are addressed through current Title V goals and through current programs within the Title V Office. However, the importance of these issues as selected through the assessment process indicates a renewed effort to identify any unknown issues or disparities to understand why these are on the minds of those who participated in the assessment activities. As Title V resources are currently allocated to efforts in these areas, review and research around these issues will continue to occur.

The priority issues related to children and youth were oral health, obesity and overweight prevention, parent education and skills resources, and access to physical and mental health services. The priority selection in these areas validated work initiated fairly recently in all these areas by Title V. Common to these efforts are partnerships with medical providers and plans to collaborate in advocating for improved screening and referral in well-child/preventive health visits, as well as partnerships within the new Oregon Health Authority which brings public health, Medicaid services, and private health plans into closer partnerships. In these areas, the selection of the age group to focus resources was determined by existing or emerging efforts within the Title V Program. These efforts are early childhood cavity prevention, healthy eating

and physical activity work in partnership with WIC and public health's chronic disease section, development of improved home visiting and early childhood systems and services, and expansion of school-based health centers.

Children and youth with special health needs (CYSHN) have a critical need to access specialized health and related care where they live. The geographic challenges of a mostly rural and frontier state and only a couple of urban centers to access to services is a continuing and growing concern. Selecting the priority goal to increase access to specialty care for all CYSHN was selected, along with improvement of resources and linkages for families and access to mental health care. Other priorities included issues related to medical home and provider training, which are existing efforts within the Title V CYSHN program and measured by national Title V performance measures.

The proposed goals and State Performance Measures are outlined below with the identified need from the public input methodologies. Criteria for selecting measures were to identify sources where data may be reported on an annual basis and where the planned activities will influence the measure's outcome. For each goal and measure is a brief "brainstorm" of the activities or capacity building that will be needed for each goal and measure. This outline is intended to show commitment to continuing conducting assessments specifically to identify disparities and both state and community level needs to address those disparities.

1. Family Violence

Priority Need: Family violence, including intimate partner violence and child abuse

Goal: Improve Oregon's systems and services for screening women for domestic and sexual violence (DSV) and for linking those affected by DSV to adequate services

Target population(s): Women before and between pregnancies

State Performance Measure: Percent of family planning clinic encounters in which relationship safety was discussed with the client. (Ahlers Family Planning Client Data-Oregon)

Activities and/or Capacity Building:
Direct or services for individuals

- Promote and educate about relationship safety with clients of family planning and home visiting services.

Enabling or linkage services for individuals or families

- Link public health family planning clients to domestic and sexual violence victim services and other community support services.

Population-based – statewide or in communities

- Develop and implement Standards of Care, protocols and best practices family planning (FP) providers and staff on screening, discussing concerns, and referral for domestic and sexual violence, and provide consultation and education about the role of family planning

providers in promoting relationship safety and linking FP clients to appropriate community resources.

Infrastructure, policies, or system-building

- Identify local expert training teams pairing public health FP nurses and DVSO staff members to facilitate trainings for FP providers and DVSO staff.
- Strengthen partnerships between local FP clinics, public health departments and DVSOs by hosting regional cross-trainings to increase understanding of respective roles and services.
- Develop and provide training and technical assistance for FP providers on Standards of Care, protocols and best practices for screening and referral and how to collaborate with local domestic and sexual violence organizations (DVSOs) via regular FP meetings and webinars.
- Develop and provide training and technical assistance for local DVSOs on how to collaborate with local health departments and family planning clinics based in other settings (community health centers, FQHCs, university student health centers, Planned Parenthood clinics, private clinics) via webinars, statewide conferences (Oregon Coalition Against Domestic and Sexual Violence Annual Conference, Attorney General's Sexual Assault Task Force Biennial SART Conference in 2012) and advocate trainings.
- Increase the capacity of FP providers to document domestic and sexual violence screening, counseling, and referral.
- Conduct assessment, including focus groups and data analysis of sub-populations who may be at higher than average risk for DV and to develop relationship safety services that are culturally appropriate.

2. Alcohol and Drug Use Prevention

Priority Need: Drug and alcohol abuse, including accessibility of services (and prevention of Fetal Alcohol Syndrome)

Goal: Decrease the risk of lifetime dependence on alcohol for teens and adults

Target population(s): Women before and between pregnancies; adolescents

State Performance Measure: Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of beer, wine, or hard liquor for the first time (Oregon Healthy Teens Survey)

Activities and/or Capacity Building:
Enabling or linkage services for individuals or families

- Enable medical providers (Pediatricians and Family Practice Physicians) to screen adolescents for alcohol use by providing them with education, screening and treatment resources.

- Provide technical assistance and tools to Nurse Family Partnership, BabiesFirst, and Maternity Case Management Programs to focus on screening teenage clients for alcohol use and provide alcohol use messages to clients (including FAS messages and education).

Population-based – statewide or in communities – services, activities

- Collaborate with the Addictions and Mental Health Division (AMHD) to leverage resources and promote the OHA's statewide under-age drinking media campaign among OFH clients, especially parents.
- Work with University Student Health Centers to promote screening and referral for binge drinking and alcohol abuse.

Infrastructure, policies, or system-building services

- Develop statewide policies to discourage under-age alcohol consumption, such as promoting legislation in collaboration with AMHD and work with University system to strengthen policies regarding alcohol use on campuses.
- Develop culturally appropriate messages for clients and education for providers to support Oregon Health Plan managed care contractors and providers in providing messages to their clients about evidence and risks resulting from early alcohol use to lifetime addictions, and for the health and safety of pregnancies and children.
- Train health workforce in School-Based Health Centers on the best practices for screening and referring services for alcohol use.
- Collaborate with the Healthy Kids Learn Better program and their Cadre of Trainers, to implement best practices of under age drinking prevention into school health curriculums.
- Support collaboration between local health departments and local implementation of evidence-based intervention for prevention of under-age drinking.

3. Mental Health Access to Services

Priority Need: Mental health, including accessibility of services

Goal: Improve Oregon's systems and services to identify, treat and support women with perinatal mental health disorders and support their infants and families

Target population(s): Pregnant women, mothers and infants

State Performance Measure: For all Medicaid clients with an expected delivery date during the calendar year, percent who were screened for depression during the time period from 9 months before delivery to 1 year after delivery. (Division of Medical Assistance Programs - Medicaid/Oregon Health Plan claims)

Activities and/or Capacity Building:
Enabling or linkage services for individuals or families

- Provide training and support to local health departments to integrate Maternal Mental Health screening and assessment into existing maternal and child health programs.

Population-based – statewide or in communities – services, activities

- Support local needs assessment and development of culturally appropriate resources related to maternal mental health through consultation and technical assistance.
- Provide technical assistance and consultation to communities to mobilize maternal mental health providers and develop community-based, coordinated screening, assessment and referral systems.
- Identify opportunities for implementing targeted outreach to vulnerable populations including those most at risk of maternal mental health disorders and those with increased barriers to accessing information and services.
- Work with public and private partners to promote public education and awareness activities related to maternal mental health.

Infrastructure, policies, or system-building services

- Sponsor and convene partners to support Maternal Mental Health Network meetings 2-4 times per year.
- Disseminate Maternal Mental Health Work Group recommendations to state and local public health agencies, stakeholders and partners.
- Work with Oregon SafeNet (211-Info) to improve the state MCH hotline's capacity to provide information and referral for maternal mental health needs.
- Identify opportunities within the Oregon Health Authority agencies to integrate Maternal Mental health education, screening, assessment and/or treatment into existing state programs serving pregnant women and children.
- Conduct ongoing surveillance of Maternal Mental Health status and needs through Oregon PRAMS and other mechanisms.
- Work with partners to facilitate access to education and training in maternal mental health for a wide range of providers including public health, addictions and mental health, medical, and early childhood providers.
- Seek funding for maternal mental health system and service improvements in Oregon.

4. Early Childhood Cavity Prevention

Priority Need: Oral health and early childhood cavities prevention, including accessibility of services

Goal: Increase the percent of children under 4 years old who have a preventive dental visit each year

Target population(s): Children ages 0 through 3 years

State Performance Measure: Percent of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year. (Division of Medical Assistance Programs - Medicaid/Oregon Health Plan Claims)

Activities and/or Capacity Building:
Direct or individual services

- Early Childhood Cavities Prevention in primary care well-child visits and nurse home visiting by screening infants, applying fluoride varnish, providing anticipatory guidance to caregivers, linking to a dental home.

Enabling or linkage services for individuals or families

- Train and advocate for enrollment assistance with dental care organizations by Healthy Kids (OHP) application assisters and sites.
- Improve linkage information on how to find a dentist for young children through websites, 211-Info, the Healthy Kids/OHP, and in community and education organizations that reach parents and providers.

Population-based – statewide or in communities – services, activities

- Implement evidence-based, culturally appropriate practices to prevent early childhood cavities Early Childhood Cavities Prevention – screening infants, applying fluoride varnish, providing anticipatory guidance to caregivers, linking to a dental home (this can be done during home visits, well child visits, etc.).
- Promote oral health as important to healthy child development among dentists, caregivers, parents, and early childhood educators.

Infrastructure, policies, or system-building services

- Include oral health in development of policies and programs related to nutrition and obesity prevention.
- Create a license or certification for designation for mid-level dental health providers to provide basic preventive dental care for infants and children.
- Improve reimbursement opportunities for LAP dental hygienists (including working in medical settings).
- Collect county level data on the status of the oral health of mothers and young children, to identify populations with high risk of development poor oral health and identify gaps in early childhood preventive practices.
- Continue implementation of the First Tooth Project, which will train medical pediatric providers to do oral health screenings and apply fluoride varnish; training general dentists to access the very young child.
- Creating a mechanism to track fluoride varnish applications across the state to determine disparities or needs for varnish across the state.

5. Resources for Parent Education and Skills

Priority Need: Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health

Goal: Improve the state's capacity for supporting parents in building parent skills and for linking parents to resources.

Target population(s): Children ages 1 to 9 years, pregnant women

State Performance Measure: Using benchmarks, develop a strategic plan for the MCH public health role and responsibilities in parent education and skills development within the context of the Early Childhood Comprehensive Systems work. Benchmarks are:

a) An MCH workgroup including local and state partners is convened to define the role of MCH in building parent resources for desired child health outcomes (as identified by Title V and Early Childhood Matters Council and Committees)
b) Existing planning efforts and parent resources are identified in relationship to the desired child health outcomes
c) A statewide needs assessment is conducted to supplement existing knowledge tied to identified child outcomes and further define the role MCH can play in developing better resources for parent education and skill development.
d) MCH in collaboration with the Early Childhood Matters and ECCS develop a strategic plan that clearly defined roles/responsibilities for MCH programs and staff related the specific child health outcomes and performance measures tied to parent resource development.

(Source: New survey and program records)

Activities and/or Capacity Building:
Infrastructure, policies, or system-building services

- An MCH workgroup including local and state partners is convened to define the role of MCH in building parent resources for desired child health outcomes (as identified by Title V and Early Childhood Matters Council and Committees)
- Existing planning efforts and parent resources are identified in relationship to the desired child health outcomes
- A statewide needs assessment is conducted to supplement existing knowledge tied to identified child outcomes and further define the role MCH can play in developing better resources for parent education and skill development.
- MCH in collaboration with the Early Childhood Matters and ECCS develop a strategic plan that clearly defined roles/responsibilities for MCH programs and staff related the specific child health outcomes and performance measures tied to parent resource development.

6. Preventing Overweight and Obesity

Priority Need: Preventing and addressing overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time

Goal: Increase the percent of children/adolescents with a healthy body weight

Target population(s): Children and adolescents ages 10-24

State Performance Measure: Percent of 8th grade students with a BMI below the 85th percentile. (Oregon Healthy Teens)

Activities and/or Capacity Building:

Direct or individual services

- Assure that health providers measure BMI of children and adolescents in preventive health visits (includes WIC clinic visits, well-child, school-based health center visits, etc.).
- Appropriate weight management education provided following weigh-ins (includes nutrition, physical activity, and screentime).
- Assure that referrals for culturally appropriate, affordable weight management made when children or adolescents have a BMI greater than the 85th percentile or have increased one percentile or more (over the 50th percentile) since their last BMI measurement.

Enabling or linkage services for individuals or families

- Website or phone resource services is available for parents about helping their children achieve and maintain a healthy weight.
- Improve and enhance Safenet resources that address obesity prevention (includes resources for physical activity and healthy eating as well as referral information for overweight children and adolescents).

Population-based – statewide or in communities – services, activities

- Promote TV Turnoff Week and screen-time awareness statewide for elementary schools and child care settings.
- Promote Walk and Bike to School Day and Safe Route to Schools for Oregon students, parents, and communities.
- Social marketing/social website promoting awareness about food industry marketing to youth for Too Many Ads: Marketing Junk Food to Kids campaign.
- Engage youth in efforts around food marketing and obesity prevention.
- Oregon's Worksite Wellness ARRA funded grant (focuses on nutrition and physical activity policies in the worksite.
- Statewide breastfeeding promotion to raise awareness about links to overweight.
- Promote preparing and eating fruits and vegetables (Farmers Markets, School efforts, Community Access to Healthy Foods, WIC vouchers).

Infrastructure, policies, or system-building services

- Child health collaborative of state and local public health staff will have targeted planning around obesity prevention activities for 0-8 year olds.
- Develop and implement nutrition standards policies for public places – including, schools, recreation centers, worksites, etc.
- Develop and implement nutrition, physical activity and breastfeeding policies in schools, worksites, and childcare.
- Collaborate with state, non-profit and local partners (working on school, childcare, screen-time, food security, breastfeeding, physical activity, access to healthy food, nutrition and physical activity policy implementation).
- Assess need and implement child care assessment tool, Right from the Start.
- Surveillance of preventive actions through PRAMS, PRAMS-2, Elementary School Health Survey and Oregon Healthy Teens Survey.

- Enhance hospital practices that support breastfeeding.
- Support statewide hunger plan with partners.
- Promote workforce development, training (including provider training) – new IOM Pregnancy weight gain guidelines; obesity prevention training through child health collaborative.
- Advocate training for child health providers on using BMI tools and nutrition, physical activity and screen-time patient education.
- Support provision of culturally appropriate, affordable nutrition and physical activity referral system.

7. Physical and Mental Health Services Access

Priority Need: Access to preventive physical and mental health services

Goal: Increase access to preventive physical and mental health services

Target population(s): Children and adolescents ages 10 through 24

State Performance Measure: Percent of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months. (Oregon Healthy Teens)

Activities and/or Capacity Building:
Direct or individual services

- Boost well visit rate among School-Based Health Center clients by implementing higher comprehensive well visit Key Performance Measure among all certified SBHCs.

Enabling or linkage services for individuals or families

- Increase utilization of Oregon's SBHCs as natural centers for outreach and enrollment into Medicaid, Healthy Kids and other insurance vehicles.
- Print and distribute adolescent well visit referral cards to pharmacists who will be immunizing adolescents according to new state law, who will be encouraged to hand out cards to parents/adolescents seeking immunizations.

Population-based – statewide or in communities – services, activities

- Train schools in the Coordinated School Health approach, including the establishment of a School Health Advisory Council (SHAC).
- Evaluate need for update and revision of adolescent well visit booklet, including the possibility of culturally-appropriate translation into Spanish; distribute widely to parents and providers.

Infrastructure, policies, or system-building services

- Contract with national expert to do provider training on the Bright Futures approach/tools in working with adolescents in comprehensive well visit.
- Collaborate with the Office of Disease Prevention & Epidemiology (ODPE) on implementing the Healthy Schools Act in Oregon.

- Work with leadership in OHA to promote Bright Futures as part of a new agency-wide standard for youth preventive care.
- Perform a policy analysis of the impact of Federal Health Reform on young adults' insurance and access to care.
- Continue to pursue expansion of SBHCs across the state that would ensure access to preventive care for youth in additional communities.

8. Linkages to Mental Health Services

Priority Need: Lack of linkages or referral pathways to appropriate mental health services for children and youth with special health need

Goal: Increase linkages to mental health services for children and youth with special health needs

Target population(s): Children and youth with special health needs

State Performance Measure: Among CYSHN who needed mental health/counseling, percentage of CYHSN who received all needed care. (Source: National Survey of Children and Youth with Special Health Needs)

Activities and/or Capacity Building:
Direct or individual services

- Continue Community Connections Network in 10 communities with emphasis on increasing mental health service linkages for CYSHN and explore expansion or other models to implement in other communities.

Enabling or linkage services for individuals or families

- Train families of CYSHN on how to navigate through the mental health system.

Population-based – statewide or in communities – services, activities

- Track, inform, and disseminate Medicaid's plan to integrate medical and mental health services statewide.
- Disseminate information to families of CYSHN regarding Medical Home.
- Support community engagement efforts in rural communities to assess, map and enagage with local mental health system, services and providers.

Infrastructure, policies, or system-building services

- Develop a mental health referral form and process to assist PHNs in making appropriate referrals to mental health services. Collaborate with mental health managed care plans to ensure the mental health referral form accepted as a protocol.
- Train public health nurses and other health care professionals to screen CYSHN and their families for needed linkages with mental health services.
- Identify disparities and specific areas of need relative to mental health services by county or region using varied sources of data, such as social/emotional/behavioral referrals to CCNs.

- Evaluate and address needs specific to transitioning youth and young adults, with emphasis on transition to adult mental health services.
- Partner with CDRC to provide webinar consultations to primary care providers on mental healthfor CYSHN.
- Partner with OHSU Child Psychologist and Oregon Pediatric Society to disseminate psychiatric consultation for primary care providers (OPAL-K).
- Identify community collaborations on medical/mental health integration.
- Offer webinar trainings to health care professionals on effective navigation, referral and utilization of the mental health system.

9. Access to Specialized Health Services

Priority Need: Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas

Goal: Increase access to specialized health and related services for underserved populations of children and youth with special health needs

Target population(s): Children and youth with special health needs

State Performance Measure: Among CYSHN who needed specialized services, % of CYHSN who received all needed care. (Source: National Survey of Children and Youth with Special Health Needs)

Activities and/or Capacity Building:
Direct or individual services

1) Provide resources for parental chromosome or other genetic tests when needed to assess recurrence risks when fetus or child is diagnosed with a genetic condition and 3rd party payer will not cover.
2) Provide resources for travel costs and travel time for families to access outreach genetics clinics in Eugene, Medford, Bend, and other communities, and to support medical geneticist and genetic counselor time to provide telemedicine visits.
3) Coordination and technical assistance with CDRC to provide telemedicine visits for multiple pediatric specialties including genetics.
4) Reconvene the Genetics Advisory Committee to Oregon Health Services Commission (HSC).
5) Provide resources to support clinician costs associated with travel to outreach genetic clinics in Eugene, Medford, Bend and other communities.
6) Provide resources to support geneticist and genetic counselor costs associated with telemedicine visits to increase and sustain rural families' access to genetic services.

Enabling or linkage services for individuals or families

- Provide education and training to CYSHN and their families on how to access specialized health and related services.

- Work to ensure barriers to specialized health care and related services are decreased, such as insurance, transportation, language barriers etc.
- Link families with public health nurses, CCN teams and other community resources that have knowledge of specialized services, their location, availability and access.
- Provide information on EHDI website, and OCCYSHN website with link to EHDI website, about importance of genetics evaluation for infants with hearing loss detected by newborn hearing screening.

Population-based – statewide or in communities – services, activities

- Disseminate information to CYSHN and their families regarding the benefits for establishing a Medical Home for their child relative to care coordination and referrals.

Infrastructure, policies, or system-building services

- Partner with CDRC to provide webinar consultations to primary care providers on a variety of topics pertinent to CYSHN including referral and linkage to specialized health services, and on their efforts to bring CDRC specialty providers out to underserved communities.
- Educate primary care providers about local specialized health and related services in their communities.
- Conduct further assessment of specialty service disparities and need including genetics, ASD, and other specific needs.
- Support staff time to work on licensure for genetic counselors legislation in 2011 legislative session.
- Support work on Oregon part of WSGSC project to improve reimbursement of genetic services by private 3rd party payers.
- Assess and analyze capacity and need for genetic counseling, pediatric clinical geneticist.
- Include genetic topics in trainings for CaCoon public health nurses, CCN providers and other community-based primary care providers.
- Support community engagement efforts in communities to assess disparities in access to specialized health and related services.

10. Access to Family Support Services

Priority Need: Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need

Goal: Increase access to family support services for families of children and youth with special health needs

Target population(s): Children and youth with special health needs and their families

State Performance Measure: State Performance Measure: Benchmarks for developing a strategic plan to address family support needs for Oregon families of CYSHN are:

1) A workgroup including families, local and state agencies/organizations, and other key stakeholders is convened to identify existing family support services within Oregon.

2) Methods to collect and capture data on family needs, family support gaps/impacts, and best practices are identified.
3) Strategies for increasing outreach and partnership activities with groups/organizations that support and assist families of CYSHN are developed.
4) Information on family needs, family support gaps/impacts, and best practices is disseminated through a variety of education and outreach efforts.
5) A strategic plan is developed which clearly articulates the roles and responsibilities for the Title V CSHCN program in addressing family support needs.

Activities and/or Capacity Building:

Direct or individual services

- Increase Family Liaisons in CCN teams to increase family support and access to family support services.

Enabling or linkage services for individuals or families

- Link families with public health nurses and CCN, or other community resources to provide resources for family to family support and other support services in their community.
- Support community engagement efforts in rural communities (and maybe more broadly) to assess and address access to family support services.
- Increase family connections in regional centers to link with FIN to increase linkages with family support services.

Infrastructure, policies, or system-building services

- Offer technical assistance and information to about specific family to family supports available in counties.
- Create and sustain OCCYSHN Advisory Group, to include youth and family members to provide input into plans and activities.
- Convene a meeting of family support groups, programs and agencies to identify priorities and create an action plan for increasing family supports for families of CYSHN.
- Track and disseminate policy that results in the restructuring of services to families of CYSHN.
- Develop and maintain website and social media sources for CYHSN, including a strong family component.
- Continue to administer Syndey and Lillian Zetosch Fund of the Oregon Community Foundation for purchase of adaptive equipment for CYSHN to pursue education.
- Train health care professionals about family needs and how to access and link families to family support services.

Outcome Measures - Federal and State

The State Title V Programs provide either direct or indirect influence on the MCH Performance and Outcomes measures, through surveillance, strategy and program implementation, systems building with partners, and policy development. Strategies and activities are selected based on the potential to change the health status of populations in the particular area represented by the performance or outcome measure. In Oregon, some of the more standard public health measures

of population health are fairly steady at low levels, such as infant mortality and low birthweight. However, other contributing factors such as prenatal care and early childhood health factors have steadily shown little improvement. Oregon's Title V Program emphasizes the systems that support families, their children and their pregnancies. This year's needs assessment has been an attempt to further narrow the goals to align with existing or feasibly possible activities and strategies that better fit in the context of the political will and changes in the health care delivery system both nationally and locally.

For the 2011-2016 assessment and plan, the Title V Offices expect to leverage and develop new program activities and partnerships that will more directly influence positive change in the performance and outcome measures. Preliminary logic models related to each of the State Title V Performance Measures will be prepared and used as guidance to identify research and evidence to implement strategies that most likely will positively influence the measure. The information in the logic models set out the first year or two strategies, activities, partnerships, deeper assessment and surveillance for the topic area.

APPENDICES

A) Title V Leadership Team and Submit Matter Experts

B) Title V Advisory Group (additional information at www.oregon.gov/DHS/ph/ch/mch_advisory.shtml

C) Explanation of Data Resources

Appendix A

Title V Assessment Leadership Team

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Appendix B - Title V Assessment Advisory Group

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Judy Cleave	Marion County Health Department
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Tameka Brazile	Multnomah Co. Health Department - Healthy Birth Initiatives
Wayne Sells	OHSU, Outside In

Appendix C – Explanation of Data Resources

American Community Survey
The American Community Survey (ACS) is a survey conducted by the U.S. Census Bureau in every county, American Indian and Alaska Native Area, and Hawaiian Home Land. The survey collects and produces population and housing information on an annual basis.
http://www.census.gov/acs/www/

BRFSS
The Behavioral Risk Factor Surveillance System (BRFSS) is an on-going telephone health survey system, tracking health conditions and risk behaviors. Data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.
http://www.cdc.gov/brfss/

CDC Lead Poisoning
The Centers for Disease Control and Prevention (CDC) Lead Poisoning Prevention Branch (LPPB) compiles state surveillance data for children age <72 months who were tested for lead at least once since January 1, 1997.
http://www.cdc.gov/nceh/lead/data/index.htm

CHS
The Center for Health Statistics (CHS) is Oregon's vital records office. Each birth, marriage, divorce, and death that occurs in Oregon is registered and filed in CHS.

Common Core of Data
The Common Core of Data annually collects fiscal and non-fiscal data about all public schools, public school districts and state education agencies in the United States.
http://nces.ed.gov/ccd/

Current Population Survey
The Current Population Survey (CPS) is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the U.S. population.
http://oregon.gov/DAS/OPB/popsurvey.shtml

Kindergarten Readiness Survey
Administered to Oregon kindergarten teachers, the Kindergarten Readiness Survey collects data on kindergarten children in most Oregon school districts.
http://www.ode.state.or.us/search/page/?id=1356

National Assessment of Educational Progress
The National Assessment of Educational Progress (NAEP) is the only nationally representative and continuing assessment of what America's students know and can do in various subject areas.
http://nces.ed.gov/nationsreportcard/

National Child Abuse and Neglect Data System
The National Child Abuse and Neglect Data System is a voluntary national data collection and analysis system created in response to the requirements of the Child Abuse Prevention and Treatment Act.
http://www.acf.hhs.gov/programs/cb/systems/

NSCH
The National Survey of Children's Health (NSCH) examines the physical and emotional health of children ages 0-17 years of age.
http://www.cdc.gov/nchs/slaits/nsch.htm

NS-CSHCN
The National Survey of Children with Special Health Care Needs (NS-CSHCN) examines the extent to which children with special health care needs (CSHCN) ages 0-17 years of age have medical homes, adequate health insurance, and access to needed services.
http://www.cdc.gov/nchs/slaits/cshcn.htm#2005CSHCN

OHT
Oregon Healthy Teens (OHT) monitors the health and well-being of adolescents through an anonymous and voluntary research-based survey. This is the Oregon version of the YRBSS (which is a national survey).
http://www.cdc.gov/HealthyYouth/yrbs/index.htm
http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/index.shtml

Oregon Population Survey
The Oregon Population Survey is a telephone survey that is conducted every two years and collects data on income, employment, education, child care, disability status, and internet usage.
http://oregon.gov/DAS/OPB/popsurvey.shtml

PRAMS
Pregnancy Risk Assessment Monitoring System (PRAMS) collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy for a sample of Oregon women.
http://www.oregon.gov/DHS/ph/pnh/prams/index.shtml

PRAMS-2
The Pregnancy Risk Assessment Monitoring System-2 (PRAMS-2) surveys Oregon PRAMS respondents when their baby reaches 2 years of age. It includes questions on such topics as well child care, child nutrition, social support, maternal physical activity and multivitamin use, childcare and screen time.
http://www.oregon.gov/DHS/ph/pnh/prams/index.shtml

Smile Survey
The Oregon Smile Survey was a statewide oral health survey among first, second and third-graders in Oregon public schools.
http://www.oregon.gov/DHS/ph/oralhealth/index.shtml

VistaPHw
VistaPHw is a software package that allows the public health community in Oregon to access and analyze population-based health data on the county or state level.
http://www.oregon.gov/DHS/ph/hsp/vistaphw/index.shtml

WFRS
The Water Fluoridation Reporting System (WFRS) is the basis for national reports that describe the percentage of the U.S. population on public water systems who receive optimally fluoridated drinking water.
http://www.cdc.gov/fluoridation/fact_sheets/engineering/wfrs_factsheet.htm

WISQARS
The Web-based Injury Statistics Query and Reporting System is an interactive database system that provides customized reports of injury-related data at the state and national level. Separate databases are maintained for fatal and non-fatal injuries.
http://www.cdc.gov/injury/wisqars/index.html

YRBSS
The Youth Risk Behavioral Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults.